Australian National Aged Care Classification (AN-ACC) Version 1.0

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Part 2: The Australian National Aged Care Classification (AN-ACC) system

Note: Part 1 was presented in November 2018. Part 2 includes results reported in 7 final reports (February 2019)
Part 1 presentation – November 2018

- Background and rationale
- RUCS study outline including process to develop the AN-ACC assessment tool
- Resident profile
- AN-ACC classification and how AN-ACC performs
RUCS Final Reports

- Report 1: The Australian National Aged Care Classification (AN-ACC).
- Report 2: The AN-ACC assessment model.
- Report 3: Structural and individual costs of residential aged care services in Australia.
- Report 4: Modelling the impact of the AN-ACC in Australia.
- Report 5: Funding model for the residential aged care sector.
The Australian National Aged Care Classification (AN-ACC) system

- AN-ACC Version 1 with 13 classes based on the capacity of the resident
- AN-ACC funding assessment tool suitable for use by external assessors
- AN-ACC funding model with three elements:
  - base care tariff
  - AN-ACC payment
  - adjustment payment
Australian National Aged Care Classification

AN-ACC Version 1 assessment and classification
What drives care costs?

- Not medical diagnosis / diagnoses
  - So Diagnosis Related Group concepts are not relevant
- Costs are driven by care burden from:
  - End of life needs, frailty, functional decline, cognition, behaviour and technical nursing needs
- These may be due to one or more diagnoses
  - Including dementia, mental health disorders, physical health etc
  - But the diagnosis per se is not a cost-driver
‘Capacity’ drives care needs and costs

◆ AN-ACC assessment captures resident capacity taking into account:
  – Physical ability (including pain)
  – Cognitive ability (including ability to communicate, sequence, socially interact, problem solve, memory)
  – Mental health issues (including depression and anxiety)
  – Behaviour (including cooperation, physical agitation, wandering, passive resistance, verbal aggression etc)

◆ It thus captures the functional consequences of health conditions (eg, dementia) rather than the condition itself
AN-ACC V1 in summary

- Admit for palliative care – one class
- Independent mobility branch
  - Two classes – with and without compounding factors
- Assisted mobility branch
  - Five classes, first split by cognition
  - Second split by compounding factors for the high and medium cognition groups
- Not mobile branch
  - Five classes, first split by function (RUG) and pressure sore risk (Braden)
  - Second split by compounding factors for two groups
Compounding factors

- Variables that explain differences in resource consumption that are incorporated to create the final branches of the tree
  - Includes cognition, behaviour, technical nursing requirements etc both as single items and in combination
  - Being careful to ensure that they do not create perverse incentives
    - Behaviour, pressure ulcers etc
- Remembering that this is a branching model, not additive
All residents

Class 1 Admit for Palliative Care

Mobility (DEMMI)

Independent mobility

Class 2
Without CF
Class 3
With CF

Class 4
Without CF

Class 5
With CF

Class 6
Without CF

Class 7
With CF

Class 8
Low cognitive ability

Class 9
Higher function

Class 10
With CF

Class 11
Lower function and lower pressure sore risk

Class 12
Without CF

Class 13
With CF

Class 14
Lower function and higher pressure sore risk

AN-ACC V1
CF = Compounding Factors
<table>
<thead>
<tr>
<th>Factor</th>
<th>FIM Motor</th>
<th>FIM Transfers</th>
<th>FIM Eating</th>
<th>FIM Cognition</th>
<th>FIM Social Cognition</th>
<th>RUG</th>
<th>Braden</th>
<th>Braden Activity</th>
<th>AKPS</th>
<th>Rockwood</th>
<th>Falls last 12 months</th>
<th>Obese Flag</th>
<th>Disruptiveness</th>
<th>Agitation</th>
<th>Daily Injections</th>
<th>Complex Wound Management</th>
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<tbody>
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<td>Independent</td>
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</tbody>
</table>

**Compounding factors in each branch**
Class profile at assessment and reassessment

- Assessment
- Reassessment
- Died
Mortality rates by class 4-6 months after initial AN-ACC assessment

- All residents
  - Class 1 Admit for Palliative Care
    - Independent mobility
      - Without CF Class 2 6%
      - With CF Class 3 4%
    - Higher cognitive ability
    - Medium cognitive ability
    - Low cognitive ability Class 8 15%
  - Mobility (DEMML)
    - Assisted mobility
    - Not mobile
      - Higher function
        - Lower function and lower pressure sore risk Class 11 10%
      - Lower function and higher pressure sore risk
        - Without CF Class 12 20%
        - With CF Class 13 22%
Why a classification?

- To inform *input* measures
- To measure and fund *outputs* (core is $ for a day of care)
- To turn crude *outcome* measures into meaningful comparisons for benchmarking and other purposes (casemix adjustment):
  - Eg, national quality indicator program
    - pressure sores, physical restraint, weight loss need to be adjusted for the mix of residents
AN-ACC costing and funding model
Fixed care vs variable costs

- **Fixed care costs** - staff time in delivering shared care, care management and additional costs of salaries and consumables driven by facility characteristics such as remoteness.

- **Variable costs** – the cost of time spent delivering individualised care to residents and the cost of clinical consumables (e.g. continence supplies, oxygen).

- Both fixed care and variable costs were allocated a share of corporate costs in the cost allocation process.
Direct, indirect and corporate costs

For total care related costs (across all facilities):
- 87% are direct costs (80% care salaries)
  - 51% - shared care and
  - 49% - individual care
- 5.6% are indirect (e.g. admin, training, insurances etc)
- 7.4% are corporate
Fixed care costs - key findings

- The overall proportion of fixed to individual care costs after full cost allocation is 51:49.
- The overall mean fixed care costs is given a Relative Value Unit (RVU) of 1.00 and all other costs are relative to this.
Major findings - 1

- Remote facilities (classified as MMM 6 and 7) incur significantly higher fixed care costs
  - More expensive consumables plus salary loadings for care staff.
- Remoteness is closely associated with small size (<30 beds), low occupancy (<80%) and indigenous care specialisation.
Major findings - 2

- Contrary to expectations, there was no difference in shared care costs per day between specialist dementia and other facilities
- Likewise specialist CALD facilities
- Likewise specialist palliative care
  - Additional costs are in the costs of individualised care
Adjustment payment

- Costs are higher in the initial period after someone enters care
  - Additional costs vary slightly by AN-ACC branch
  - Adjustment period is longer for some classes than for others
  - But variations not sufficient to justify different adjustment payments

- Average adjustment period is 16 weeks
  - But this is the average, not all residents are the same
  - Pay as a one-off lump sum adjustment payment
    - Adjustment is not a per diem process
Adjustment period cost curve
AN-ACC RVUs and NWAU

◆ **Relative Value Units (RVU)**
  - A measure of relative **cost**
  - One set of RVUs for the individual care costs
    - calibrated so that the average cost of one individual day is RVU=1.00
  - One set of RVUs for the fixed care cost groups
    - calibrated so that the average cost of one fixed care day is RVU=1.00

◆ **National Weighted Activity Units (NWAU)**
  - A measure of relative **price** in the AN-ACC funding model
  - One set of NWAU calibrated across the three elements in the funding model
    - Individual care (13 AN-ACC classes), fixed care (5 base care tariffs) and the adjustment payment
## Base care tariff

<table>
<thead>
<tr>
<th>Base Care Tariff</th>
<th>Facility description</th>
<th>RVU</th>
<th>NWAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Indigenous, MMM=7</td>
<td>4.63</td>
<td>1.80</td>
</tr>
<tr>
<td>2</td>
<td>Indigenous, MMM=6</td>
<td>1.62</td>
<td>0.78</td>
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<tr>
<td>3</td>
<td>Non-indigenous, MMM=6-7, &lt; 30 beds</td>
<td>1.87</td>
<td>0.68</td>
</tr>
<tr>
<td>4</td>
<td>Non-indigenous, MMM=6-7, 30+ beds</td>
<td>1.06</td>
<td>0.52</td>
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<tr>
<td>5</td>
<td>Specialised homeless</td>
<td>1.79</td>
<td>0.92</td>
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<tr>
<td>6</td>
<td>All other RACFs</td>
<td>0.95</td>
<td>0.49</td>
</tr>
</tbody>
</table>
## AN-ACC NWAU

<table>
<thead>
<tr>
<th>AN-ACC class</th>
<th>Resident description</th>
<th>AN-ACC NWAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Admit for palliative care</td>
<td>1.00</td>
</tr>
<tr>
<td>Class 2</td>
<td>Independent without CF</td>
<td>0.19</td>
</tr>
<tr>
<td>Class 3</td>
<td>Independent with CF</td>
<td>0.31</td>
</tr>
<tr>
<td>Class 4</td>
<td>Assisted mobility, high cognition, without CF</td>
<td>0.21</td>
</tr>
<tr>
<td>Class 5</td>
<td>Assisted mobility, high cognition, with CF</td>
<td>0.37</td>
</tr>
<tr>
<td>Class 6</td>
<td>Assisted mobility, medium cognition, without CF</td>
<td>0.35</td>
</tr>
<tr>
<td>Class 7</td>
<td>Assisted mobility, medium cognition, with CF</td>
<td>0.49</td>
</tr>
<tr>
<td>Class 8</td>
<td>Assisted mobility, low cognition</td>
<td>0.54</td>
</tr>
<tr>
<td>Class 9</td>
<td>Not mobile, higher function, without CF</td>
<td>0.54</td>
</tr>
<tr>
<td>Class 10</td>
<td>Not mobile, higher function, with CF</td>
<td>0.87</td>
</tr>
<tr>
<td>Class 11</td>
<td>Not mobile, lower function, lower pressure sore risk</td>
<td>0.83</td>
</tr>
<tr>
<td>Class 12</td>
<td>Not mobile, lower function, higher pressure sore risk, without CF</td>
<td>0.81</td>
</tr>
<tr>
<td>Class 13</td>
<td>Not mobile, lower function, higher pressure sore risk, with CF</td>
<td>1.00</td>
</tr>
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</table>

Adjustment payment: 5.28
An example: NWAU=$100

<table>
<thead>
<tr>
<th>AN-ACC class</th>
<th>Resident description</th>
<th>Base Care Tariff 1</th>
<th>Base Care Tariff 2</th>
<th>Base Care Tariff 3</th>
<th>Base Care Tariff 4</th>
<th>Base Care Tariff 5</th>
<th>Base Care Tariff 6</th>
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<tbody>
<tr>
<td>Class 1</td>
<td>Admit for palliative care</td>
<td>$280</td>
<td>$178</td>
<td>$168</td>
<td>$152</td>
<td>$192</td>
<td>$149</td>
</tr>
<tr>
<td>Class 2</td>
<td>Independent without CF</td>
<td>$199</td>
<td>$97</td>
<td>$87</td>
<td>$71</td>
<td>$111</td>
<td>$68</td>
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<td>Class 3</td>
<td>Independent with CF</td>
<td>$211</td>
<td>$109</td>
<td>$99</td>
<td>$83</td>
<td>$123</td>
<td>$80</td>
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<tr>
<td>Class 4</td>
<td>Assisted mobility, high cognition, without CF</td>
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<td>$99</td>
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<tr>
<td>Class 5</td>
<td>Assisted mobility, high cognition, with CF</td>
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<td>$115</td>
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<td>$86</td>
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<tr>
<td>Class 6</td>
<td>Assisted mobility, medium cognition, without CF</td>
<td>$215</td>
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<td>$87</td>
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<td>Class 7</td>
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<td>$127</td>
<td>$117</td>
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<td>Class 8</td>
<td>Assisted mobility, low cognition</td>
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<td>$132</td>
<td>$122</td>
<td>$106</td>
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<td>Class 9</td>
<td>Not mobile, higher function, without CF</td>
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<td>$132</td>
<td>$122</td>
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<tr>
<td>Class 10</td>
<td>Not mobile, higher function, with CF</td>
<td>$267</td>
<td>$165</td>
<td>$155</td>
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<td>$179</td>
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<td>Class 11</td>
<td>Not mobile, lower function, lower pressure sore risk</td>
<td>$263</td>
<td>$161</td>
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<td>$135</td>
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<tr>
<td>Class 12</td>
<td>Not mobile, lower function, higher pressure sore risk, without CF</td>
<td>$261</td>
<td>$159</td>
<td>$149</td>
<td>$133</td>
<td>$173</td>
<td>$130</td>
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<td>Class 13</td>
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<td>$280</td>
<td>$178</td>
<td>$168</td>
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<td>One-off adjustment payment</td>
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</table>
An example: NWAU=$172

<table>
<thead>
<tr>
<th>AN-ACC class</th>
<th>Resident description</th>
<th>Base Care Tariff 1</th>
<th>Base Care Tariff 2</th>
<th>Base Care Tariff 3</th>
<th>Base Care Tariff 4</th>
<th>Base Care Tariff 5</th>
<th>Base Care Tariff 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Admit for palliative care</td>
<td>$482</td>
<td>$307</td>
<td>$289</td>
<td>$262</td>
<td>$331</td>
<td>$257</td>
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</table>
Key outcomes

- AN-ACC Version 1 with 13 classes based on the capacity of the resident
- AN-ACC funding assessment tool suitable for use by external assessors
- AN-ACC funding model with three elements:
  - base care tariff
  - AN-ACC payment
  - adjustment payment
What else can this type of system deliver?

- Better data to understand resident profile and changing needs and costs
- If resource utilisation classes contain residents with similar needs, they can be used to measure quality and outcomes in meaningful ways
  - eg, hospital transfer rates adjusted for casemix
  - eg, rates of functional decline adjusted for class at entry
  - eg, rates of adverse events – falls, medication errors, injuries – adjusted for casemix
Modelling the results
Average RVU

- CALD facility
- Dementia facility
- Homeless facility
- Indigenous facility
- Mental Health facility
- Palliative Care facility
- ≤64 years
- 65-84 years
- ≥85 years
- ATSI
- Not ATSI
- Prefer not English
- English

AN-ACC vs ACFI
30 recommendations
AN-ACC classification

1. That the Australian National Aged Care Classification (AN-ACC) Version 1.0 be adopted as the national standard classification for residential aged care
2. That the Australian National Aged Care Classification (AN-ACC) Version 1.0 Assessment Tool be adopted as the national standard funding assessment for residential aged care.

3. That all new residents be assessed by an independent assessor using the AN-ACC Assessment Tool within four weeks of entering residential aged care.
AN-ACC assessment (2)

4. That residents requiring reassessment be assessed by an independent assessor using the AN-ACC Assessment Tool.

5. That aggregate de-identified data captured in the AN-ACC assessment be released in the form of an annual public report on the needs of residents in the residential aged care sector.
AN-ACC reassessment

6. That the new AN-ACC funding model allow for reassessment based on significantly increased needs as indicated by (1) a significant hospitalisation (2) a significant change in mobility and/or (3) a standard time period
   - 12 months for Classes 2 to 8 (classes with lower mortality rates) and 6 months for Classes 9 to 12 (frailer and higher mortality rates)

7. That the Commonwealth consider the introduction of reassessment charges for any home that routinely triggers unnecessary reassessments.

8. That there be no requirement for reassessment in the AN-ACC funding model.
Internal assessment for care planning

9. That a best practice needs identification and care planning assessment tool be developed for use by residential aged care facilities.

10. That, as a condition of subsidy, each resident undergo a care planning assessment at least annually and that the outcomes of this assessment be discussed with residents and carers and be used as the basis of an annual care plan.
11. That the subsidies payable to homes for the care of residents consist of three components (base care tariff, AN-ACC payment and adjustment payment), each of which is expressed for funding purposes as a National Weighted Activity Unit (NWAU).

12. That there be a specified table of base care tariffs reflecting the structural costs of delivering care in different types of facilities.
AN-ACC funding model (2)

13. That, in residential care facilities in remote areas (MMM 6 or 7), the base tariff be based on approved beds (capacity) with all other base tariffs being based on occupancy.

14. That, in addition to the base tariff, homes receive a daily subsidy for each resident based on their AN-ACC class.

15. That the tariffs, classes and NWAUs set out in Report 6 be adopted in the first version of the AN-ACC funding model for residential aged care.
Initial AN-ACC class assignment

16. That residential aged care facilities not be advised of the resident’s exact AN-ACC class until after the person is in care.

17. That the default payment class at entry be Class 2. Payments are retrospectively adjusted to the date of entry once the assessment is undertaken.
Adjustment payment

18. That the one-off adjustment payment be set at 5.28 NWAUs.

19. That the Commonwealth, working through the Department of Health and the Aged Care Quality and Safety Commission, build strong accountability into the system to ensure that the adjustment payment be used for the intended purpose, not added to the bottom line and not contracted out to third party providers.
Existing Commonwealth subsidies

20. That existing Commonwealth subsidies be addressed in three different ways:

- Discontinue homeless supplement and adjusted subsidy reduction.
- RCS payments for grandparented residents be progressively phased out with all current RCS recipients to transition to the AN-ACC within two years.
- Daily residential respite subsidy, oxygen supplement, enteral feeding supplement and veterans supplement be the subject of supplementary RUCS studies with current recipients being grandfathered until the results of the supplementary study are available.
Planned transition strategy

21. That the Commonwealth develop a national transition strategy with progressive implementation of the AN-ACC over two years.

22. That the Commonwealth adopt a stop-loss policy for any home that would experience a significant funding decrease under the AN-ACC model with an initial stop-loss threshold of 5% and transition payments payable for up to two years from the date of transition.
Planned transition strategy

23. That a national implementation plan with indicative time lines, costs, consultation strategy and communication plan be developed by the Department of Health.

24. That the Commonwealth undertake an annual residential aged care costing study and, informed by that, determine the dollar value of an NWAU each financial year.
Assessment workforce

25. That, in the context of broader reform proposed for aged care assessment, the Commonwealth adopt a national networked external assessment model for the AN-ACC funding assessment.

26. Irrespective of the broader organisational aspects, external assessment be undertaken by credentialed registered nurses, occupational therapists and physiotherapists who have experience in aged care, complete approved AN-ACC assessment training and comply with continuing professional development requirements.
Enablers

27. That the Commonwealth develop an Information Technology strategy for the progressive implementation of the AN-ACC funding model.

28. That the Commonwealth work with peak bodies to develop and implement a change management strategy.
Ongoing research and development

29. That Government commit to an ongoing aged care research and development agenda that builds on the work of the RUCS and that includes assessment, classification, costing and outcome studies.

30. That a study equivalent to RUCS be undertaken in the community aged care sector with a view to expanding AN-ACC so that it includes aged care delivered in all settings.