Transcript

0:00
Good morning, my name is Jaye Smith, I'm the First Assistant Secretary of the Residential and Flexible Aged Care Division in the Department of Health. I'd like to welcome you to today's forum to discuss progress and next steps on the Resource Utilisation and Classification Study.

0:13
I'd like to start by acknowledging the traditional owners of the land in which we're meeting today the Ngunnawal people, I pay my respects to elder's past and present and I extend that acknowledgement to any Aboriginal and Torres Strait Islander people in the room with us today.

0:29
Well, I'm pleased to confirm that the Minister for Senior Australians and Aged Care, the Honorable Ken Wyatt, has now received seven reports from the University of Wollongong which collectively deliver the Resource Utilisation and Classification Study which I will refer to throughout as RUCS.

0:45
With this milestone we've reached a new phase in the long term reform of residential aged-care funding taking us closer to being able to realize a more stable and equitable funding system, before I go on I want to acknowledge the excellent work of the University of Wollongong and its key personnel Professor Kathy Eager, who'll speak to us shortly, Jenny McNamee and Dr Rob Gordon. I also acknowledge the studies Sector Reference Group, the reference group provided advice in relation to the design and implementation of the RUCS over the past 18 months.

1:21
Many other group are here today, and I'd like to thank you for your input, I'd also like to acknowledge the departmental officers who've been closely involved in this project for their contribution. Nigel Murray who you'll hear from later on when we have a have a facilitated discussion, Melissa Crampton, Rob Montefiore-Gardner along with the broader funding reform team.

1:43
Before calling on Kathy, I want to take a few minutes to talk through how we've got to this point and what the next stage looks like. In 2017 government commissioned two reports into
the future of aged care funding approaches. These were the “Review of the Aged care Funding Instrument (ACFI)” by Applied Aged Care Solutions led by Richard Rosewarne. The second report was “An Alternative Aged Care Assessment, Classification Systems and Funding Models” report. This was developed by the Australian Health Services Research Institute at the University of Wollongong. This blue sky project examined aged-care funding models around the world and considered what type a funding model will be best for residential aged-care in Australia. These reports were commissioned following a period of instability in the ACFI and a recognition that continues to be shared by all, that the ACFI is no longer fit for purpose. In particular a key finding of the University's review was that the ACFI no longer appropriately discriminates between residents in terms of what drives the costs of delivering care.

2:51
Reflecting on these broader concerns about ACFI the Rosewarne report recommendations which proposed to retain and update ACFI were not progressed in favour of a more ambitious program to develop a robust and stable funding tool for the longer term. Building on the University's observation that there is a lack of evidence about what drives costs in residential aged-care. The market was approached for quotes to undertake the RUCS. The University of Wollongong was that was successful in the tender process and initially proposed three studies.

3:22
The first was a collection of resident assessment service utilization and financial data which was analysed to develop a case-mix classification.

3:31
The second was a shared cost analysis to understand differences in cost drivers between different types of facilities, including facility size and location as well as differences that may result in seasonal effects this analysis informed the design of the funding model.

3:46
The third study was a case-mix profiling study to test the feasibility of implemented implementing the blended funding model a fourth study was subsequently added as results from the first three studies started to emerge.

4:00
This fourth study looked at reassessment including the rate and extent of changes in residents care needs over time. The seven reports that we have out represent an outstanding piece of work involving the voluntary participation of more than 4,500 unique residents and 188 facilities.

4:20
It has established a base on which the future of residential aged-care funding can be considered the reports have proposed a new funding assessment model using an independent work force a new assessment tool a new resident classification scheme and a funding model
that distributes basic subsidy funding between providers based on the objective characteristics of like care recipients and like facilities.

4:47

There are a few areas where we need to do some extra work, for example we're commissioning further data analysis or facility costs in MMM 3, 4 and 5 services, this is to validate the results produced through the RUCS with a larger sample size this reflects findings in the final report that the shared costing triple in one to five services would be the same.

5:07

We think it's particularly important to validate this for regional and rural areas consideration will also need to be given to other areas of residential care funding not addressed by the RUCS in particular respite care and the viability supplement. These are examples of the types of issues that might emerge as we get into the detail of the recommendations It also highlights the possible need for further refinement of the model as you'd also be aware on 10 February 2019 the government announced funding of $4.6 million to trial the assessment tool and classification approach to assess suitability for national implementation.

5:46

The trial will field tests supporting software hardware IT systems and IT support arrangements as well as the assessment workforce management processes. It will recruit and deploy an independent workforce of clinically qualified assessors to assess their care needs of a representative sample of aged care recipients using the proposed new funding tool and it will validate the models assumptions about distribution of care recipient classifications to investigate potential service level and overall financial implications of introducing the funding elements of the model.

6:18

We're currently engaged in detailed design of the trial and in preparing to procure the necessary assistance to operate the trial recruitment of participating facilities care recipients and the assessor workforce is expected to occur from July to September 2019. Assessments are expected to be carried out from October 2019 to March 2020 reporting on results is expected between April and June 2020.

6:45

If you'd like to be involved in the trial, please make contact with a member of the department today or in the near future, we're maintaining a register of interested organizations and have already received a number of approaches. Today's session also marks the commencement of an extensive consultation process, everyone who's been involved in the project as a participant or stakeholder is excited by the results and the possibilities but the size of the task of shifting to a new funding tool is also recognized.

7:15

The consultation process is intended to give all stakeholders an opportunity to consider the proposed new tool and what it would mean for them, the University’s made thirty
recommendations to which stakeholders and government need to give consideration. We encourage analysis and feedback the combination of the consultation and the trial will allow for any refinement of the model to occur and will inform options for possible national rollout, as well as hearing views today the seven reports and a consultation paper including a statement from the minister will be released very shortly the consultation paper is focused on the findings of the rocks and the proposed funding model and is a more formal process of receiving feedback with a greater reach details of the consultation paper will be on the residential aged-care funding reform web page with links to the department's consultation hub.

8:09

The Consultation Hub will provide information on how to submit feedback on the paper, the relevant web links will be provided to you today. And we'll also be putting a broader notice out to the sector. I'll shortly invite Kathy to come up and present her findings and questions are invited throughout.

8:24

The presentation will be filmed and uploaded to the department's website, people asking questions will not be filmed but Kathy's answers will be this overview is also being filmed after Kathy's presentation and lunch which is scheduled for 12:30. We've arranged for a facilitated discussion on key components of the proposed model, this will enable us to hear and take on board your initial views and draw out other matters that we might need to consider throughout the consultation process. More instructions about this session will be will be provided at the time when we hand over to our facilitator Lynette Glendenning anything that we don't get to before 12:30 in terms of questions and answers with Kathy we can also pick up after that afternoon session commences.

9:08

So thank you for your patience with my opening remarks, and I'm pleased to now introduce and hand over to Kathy Eager.

9:16

Good morning, everybody. Can I join Jaye in acknowledging the traditional owners of the land and I also reinforce Jaye’s comment that I'm happy to take comments and questions as I go which will be really talking through to lunch but also if you reflect on it and want to raise issues this afternoon with me, you also have the opportunity to do so.

9:43

What I'm going to do is really pick up and make a point that this is part two, we did part one in this room last November that was also a two-hour presentation from me. I will show you the web link for that in a minute, but I am NOT going to really go back over what I did there and what I did do was to go back through the rationale about why we did this.

10:08

I went back through the four studies and how we did them. I talked about how we developed the assessment tool. I provided a profile of residents and their needs and I would point you to
that, we did the way we did the first study was that we assessed 2,000 people. We did we split that data set into two, we developed the classification on 1,000 and then we tested it on the other thousand. The thousand that we developed it on is the profile that I presented last November. We then tested it on the other thousand. We got the same result.

10:48

We then tested it on the four thousand people in the modelling study. We got the same result. So the results are very robust. We haven't updated it from the first thousand all you have to do is magnify it by four and you'll get the same result that we got.

11:02

It is very important because it's the first time we have empirical evidence of the needs of people in this sector and that it is really important in the life of the current political climate and in the light of the considerable community concern about how we care for older people in this country and having empirical firm evidence of work what that cohort looks like for me is a really important contributor from the study and I will acknowledge they know the homes and the participants the residents in this study.

11:36

We did it in four and a half thousand in five thousand residents. We had less than fifty who did not consent and that's the other thing I would say in terms of consumer feedback the only thing people complained about was that they thought that the staff who assess them were lovely and they would have liked more time with them.

11:55

So we need to be very careful about engaging with resident people want to be engaged in decisions about their care and they want to be able to tell their story and the information we have in our study is a very powerful. We've turned it into quantitative data but sitting behind that these qualitative stories about every single person and their needs and we shouldn't forget that.

12:18

So in the last presentation I talked about the tool I talked about the profile, I showed you the classification and how it performed and I'll revisit that a tiny little bit today but I'm not going to go back through the other stuff the two websites up here are the two places that for those of you who would like to spend another two hours of your life revisiting that you can happily go to either the department's website or to ours.

12:45

Jaye's talked about the Minister has now approved the release of the seven reports, they will go on that website with today's presentation as well that gives you an opportunity to both engage with your own stakeholders as well.

13:01
The seven reports I'll just go through them very quickly, Report one is actually the classification itself how we developed it, what it looks like, how it performs I covered that in the first presentation.

13:15

The second report and the reason we've done seven is we didn't want to present people with a 400-page report, we've really targeted these two different audiences. The second report is really going to be of most interest I think to clinicians. It's how we developed the tool what the tool looks like. I will just say something about the final assessment tool.

13:34

I've got one copy with me. There are four. It's four pages only It can be completed by one experienced assessor in less than one hour and the same tool works for assessment and for reassessment. So that's really important and that represents a significant saving in the sector.

13:57

That we're now talking about a very efficient way to assess for funding purposes and I will come back to that but I'm happy that I'll just pass this one copy around as I go some people already have it I think. The third report looks at structural costs and individual costs we went into with a hypothesis which we have demonstrated that said there's a whole bunch of care. Costs which are fixed and I'm not talking about how to go recommendations but every single home tonight is staffed by staff irrespective of the care needs of individuals in care tonight every dining room has got staff standing there available to everybody but not being allocated in terms of their time to anybody and we need to understand the fixed care costs of having the door open.

14:54

Theory about that the model we developed is the case and the headline and I'll come back to it 51% of all care costs in the country are shared equally between our residents and 49% of costs are individualized and that's what that report really sets out and shows the other side of that goes giving a bit of a headline is that those fixed care costs are structurally different in different parts of the country and in different types of homes

15:25

We have set what we are calling six base care tariffs based on home descriptors for that 51% so we've got a classification to fund the individualized component of care for an individual and six base care tariffs for the fixed care costs and I'll show you what they look like in report four we have modeled the impact that is a randomized sample across the country of care homes four thousand people, four and a half thousand people a lot of people very happily and willingly and we're very grateful agreed to organise for residents in their homes to be assessed as part of that and I will show you what that looks like.

16:08

There are some interesting differences by state and territory but the results again are very robust in Model 5. We've actually in report 5 set out the detail of the funding model I will walk you through that as part of this presentation the key bit but there's a fair bit of detail in
that I'm sure that the finance people will be more interested in that than the nurses but these we're very open that these reports should be invaded made available to everybody and people will self-select the reports of interest.

16:40

If you only read run report, though, you should reread report 6 this is a synthesis of all the reports and it contains 30 recommendations we have made to government I will walk you through the 30 today but that report sets out the 30 recommendations and the rationale, Report 7 is for those who have problems with insomnia, If you have not still got to sleep after the other six you may wish to read the technical appendices which have all the technical detail that we didn't try and put into the other reports so we have deliberately aimed that these reports are 20 to 30 pages accessible in one read, targeted to different parts of the sector understanding that there's a very diverse group of stakeholders who are very interested in this work.

17:34

There are three major outputs and we're calling this the Australian National Aged Care Classification and it's a system, it's not a smorgasbord where you pick bits and pieces and we're very hoping that the sector doesn't react to it. Is this sort of almost more than we're very hopeful the government doesn't either it's designed as a system that works together the three elements are a casemix classification, a classification of the needs of residents based on their capacity there are thirteen classes.

18:09

That was really important. Some people were very concerned at the beginning and said good heavens you're going to take the model that was in hospitals and you're going to come up with 200 classes and there's 64 in the current ACFI. We've come that we've got that down to 13. I will show you that thirteen classes and I'll show you what it looks like two thousand people were involved in were assessed for that classification. We went back and we assessed half of them a thousand of them between four and six months later.

18:38

I will show you what that looks like as well how people changed over that's on average five months between the two assessment points using those thirteen classes. Okay, the second element is the assessment tool. That's the tool that's going around. It is four pages that is a very different assessment tool than the current ACFI and the reason for that is that we are deliberately aiming to be parsimonious to only include in that assessment items that are help us allocate somebody to the appropriate funding model level.

19:12

We have separated the concept of assessment for care planning from assessment for funding do not believe we are saying that homes don't need to be doing assessment quite the reverse. We are saying that homes need to really beef up and do better quality assessments focused on meeting the needs of residents independent of the funding issues and that's about driving best practice. It's a very clear message and I will we do have recommendations about that. The
third is the funding model it has three elements as I've already described but just to go through them again and I will go through this in detail.

19:52

The base care tariff for the shared costs of having the door open delivering care, six levels based on the structure of the sector and I'll explain that the third the second element is AN-ACC payment for the individualized needs so in each resident would be funded according to the base care tariffs of the place they're sitting in not surprisingly small indigenous, low occupancy units in remote locations have a substantially higher base care tariff than Metro for example, 13 payment classes. The last is an adjustment period, this recognizes that when people come in to care there is an additional adjustment period, where care needs are high people often disoriented homes need to get to know the resident get to know their family work with them to identify their strengths, preferences, appetite for risk sort out their pain and malnutrition, etc, etc. We understood that there might be an adjustment period it turns out the adjustment period is larger and longer than we had thought but there is a very clear evidence base to pay an additional adjustment period payment upfront.

21:15

I also want to make a comment about that in terms of incentives for good practice. We are proposing that people be assessed prior to that adjustment period and they not be assessed again at the end of it if a home adequately manages behaviour managers react you know does a good rival Montex Graham sorts out pains sorts out malnutrition and as a result the person becomes more independent, but that higher level of payment stays in the home. Be very clear. This is about driving incentives for good practice and resolving the current problem in the current ACFI, which is about the perverse incentives. It has about matter about not adequately managing behaviour and physical health problems and I think that's really important and I'm not saying that that's what homes do but I'm talking about the way funding models are designed.

22:16

And the explicit incentives in them so I'll show you what that it adjustment payment looks like anybody want to ask for comment or question be or I just go back and revisit very quickly the assessment and classification. No, okay, I want to go back to some really basic ideas hat is it about a person and I've used the same example all the time somebody you're an experienced age care provider you go on holidays you come back you make three new residents you have a ten minute chat to them and in ten minutes, you actually know this person's lonely, They're not going to need too much. This person will be in the middle and this other person over here is really high need what were you looking at and we ask that question of our expert we had for expert clinical panels, We ask that of our providers that we were working with as well and the answer came back all the time that it was not actually the medical diagnosis but rather the things on my second doc point that care needs are driven by end-of-life needs by a person's mobility to manage activities of daily living by concepts to do with frailty, cognition and behaviour and so on the underlying cause might be a medical diagnosis but a person may not move around may not be mobile for a hundred different reasons, It may be that they've got severe arthritis or it may be that they've got severe dementia and that's actually now at a point that they've lost their physical mobility, they may
have a broken leg or they may have such malnutrition that they don't have the standing and
the energy but irrespective of the cause their need for care is driven by the fact that they're
not mobile rather than the underlying medical diagnosis and that has two implications that are
important for us one is diagnosis related groups as are used in hospitals are not relevant here
because homes are not providing diagnosis related care.

24:31
And that's a really important take-home message diagnosis related concepts are not relevant.
Even if the diagnosis is an underlying problem that led to somebody being in care, it's not the
focus of the care once they're in care the second is that there's been a lot of stereotypes in the
in the sector we talk about people with dementia people with mental health people with
arthritis people with pain and in fact, somebody said to us recently we're really concerned.
Your classification doesn't have special classes for people with dementia well, actually
dementia is measured and incorporated in every single level of the classification but there's
not separate classes for people with dementia because people with dementia might have
anything from very mild dementia to profoundly disabling dementia and what's driving their
need for care at this point is their how they're managing with their capacity to live
independently.

25:32
So the key concept in the assessment and this is why you can't have a computer doing it
through a centralized login is that you need an expert assessor to assess what a person is
capable of doing their capacity rather than what they currently do, we would describe that
when we train as can do versus do do and where a person's capacity is not just their physical
capacity, but also their cognitive capacity motivation and so on so capacity. The assessment
is four pages. We are asking expert assessors what is this person capable of doing take into
account their physical abilities including things like pain? Their cognitive abilities if
somebody starts getting undressed and then they forget what they're doing and then they get
dressed again because I can't sequence activities anymore. They're not independent forgetting
dress, even though they're physically capable of doing so even though we're measuring
mobility and dressing ability. We're actually also measuring underlying behaviour cognition
and so if somebody can't walk down the corridor because they'll forget where they're going or
are aggressive to another person and so they can't be independent doing that. They're not
independent for mobility there's everybody comfortable with that concept because that
concept drives the whole classification.

27:11
You will not see special classes for dementia and special classes for something else. We're
talking about the functional consequences of the underlying health conditions rather than the
health condition itself. Everybody comfortable?

27:30
The second thing about that capability is that it means that people can be assessed when
they're still at home or indeed even in hospital. If the Assessor is expert enough to be able to
determine their capability once they're no longer in that environment. If you are assessing
somebody lying in a bed in a medical ward on what they're doing you would end up with a
very different assessment than an assessment based on what a person is capable of doing. This is an expert assessment and that does mean you'd need a specialist investment in an assessment workforce. So the issues that are the underlying issues are to do with physical ability to do with cognitive ability to do with mental health issues. I think the feedback we got is that one of the most unrecognized problems in the education sector is anxiety and a lot of people with underlying anxiety are being incorrectly diagnosed as having depression or incorrectly diagnosed as having dementia but the underlying problem is severe fear and anxiety and I think again, this whole issue once you go down the diagnosis path you end up with 500 diagnoses and they don't help you so we're interested in the functional consequences of a health condition rather than the can itself.

29:06

To give you a summary the 13 classes, we have one class for people who come in to care now with the explicit purpose of receiving palliative care all of the homes we've worked with everything have reported a very big increase in this people coming in often referred by specialist palliative care or by hospitals the person cannot live at home they live alone. They don't need to stay in hospital and they're coming in in an expectation of their receiving end of life care, hospice care in a home We have created one class for that group that group is very Small in our data set because we were assessing people already in care rather than people coming through the door, but we have no doubt based on consultation in the sector that that will be an increasingly important group and represent a significant amount of effort.

30:06

We then split everybody based on their ability for mobility into those who are completely independent in terms of what they're capable of doing only 15% of people independently mobile. There are two classes only for those who are independent and that's because there's only 15% with them without compounding factors and I'll show you those in a minute 50% 55% also of people require assistance and we're not talking about with a cane or device. We're talking about physical assistance, which is either coaxing, supervision or in fact physical assistance a bit over 50% for that cohort we then split that cohort into classes based on their cognitive ability People who is severe cognitive impairment. There's hardly anybody in the independent group. They just don't get there the assisted mobility group splits into cognition and then they split on compounding factors and then 30% of people one in three cannot mobilize in bed. They can't wait there and the sizable proportion can't even lift their bottoms and reposition in bed.

31:35

That's 30% now they look like the palliative care group and we've pegged the palliative care group to that group So the non-mobile group the first split is by the late-loss ADLs, activities of daily living using a tool called the resource utilization groups the RUG activities of daily living scale. This is just four items. You'll see it in the assessment tool it's the core of the American case-mix classification for nursing homes and skilled nursing facilities. It picks up the late-loss ADLs the last coolest people can do before they die. Therefore it's really good for this very high need cohort and also into groups based on a person's risk of a pressure sore if a person develops a pressure sore, they do not go to a higher paying class.

32:31
People are allocated to classes based on their risk of developing one again this is about creating the right incentives in the sector to appropriately manage risk, if a person's at high risk and come and one of those features of being at high risk is that you can't get out of bed you can't move around that makes you with our risk. There is that is the most expensive class compounding factors all the way through you'll see pidgeon pairs and if I just go back a pidgeon pair is the independent branch there's a pidgeon pair one class for people without compounding factors one with and they happens all the way through the classification compounding factor those are the characteristics that drive need for care that includes cognition behaviour some technical nursing requirements we have been very careful about incentives particularly about perversity and that's a very strong message that we've had from the sector that the sector is always trying to do deliver good quality care against the incentives in the system rather than in favor of the incentives.

33:50

We also want to pick up an idea that this is a technically a branching classification not additive. This in this slide is what the classification looks like. It's exactly the same thing I just showed you so admit from palliative care is class 1. Splitting people into 3 groups based on the DEMMI that is the De Morten Mobility Index Australian.

34:12

The classification assessment tool new to this sector came out of our clinical expert reference group committee was really well received and regarded by the people who used it as really helpful and easy-to-use to classes for people who are independent that's classes 2 & 3 not surprisingly the people who are in the lowest funded class a class to people who are independent and without compounding factors. There's not that many of them and I suspect in terms of time.

34:52

If I'd looked at if we done this 10 years ago, that would have been quite a big class and twenty years ago when residential aged care was a lifestyle choice. It would have been a much bigger class, it's a tiny class because residential aged care is no longer a lifestyle choice and that's about the environment we're working in.

35:13

Classes 2 & 3 for those who are independent the assisted mobility group split into high medium and low cognition. It's a very low cognition actually the local mission group was not big enough to split and that's because the low coordination group mostly can't even do assisted mobility.

35:30

They're in the next group the others those split on with him without compounding factors the non mobile split into high and low, the high specs on with them without compounding factors and the low splits on risk of pressure area saw and I would just say this is relative risk. Everybody's at risk in that cohort. It's just lower and higher and the last two groups which are actually the highest paid in the classification. Those people you can't mobilize we've got low function who've got who are at high risk of pressure areas and with other compounding
factors, that's class thirteen we have pegged plus 1/2 plus their team for payment purposes. That also means that if somebody becomes palliative once they're in care they all end up in class thirteen rather than in class one but we've pegged the two together.

36:37

I've talked all the way through about compounding factors, the compounding factors are a little bit different in each of the branches of the tree. I don't intend to go through it in getting in any detail, but I would just point out. These are the items. So for the independent if I just use that as an example recognition. Resource utilization group's activities of daily living scale AKPS is the Australian Modified Karnofsky Performance Scale. It's a measure of palliative performance agitation, daily injections has worked out for that cohort to be a really good proxy for all sorts of other nursing needs it's not that there's you're not measuring them. It's that it's such a good proxy for the others you don't need to incorporate all with the others as well. You'll see actually did talk to our panel and said well if you don't need some motor for the non-mobile group because they or nobody gets scores high on that because by definition none of them should we even collect it we have agreed that the tool is only four pages and for the next several years as we develop the evidence base about this sector the same items should be asked of everybody but there is no reason in a more mature system that you wouldn't create an algorithm and based on the answers to the mobility question, That would send you down a different branch and you'd only ask those items in the tool relevant for the branch but we are not proposing to do that. Now. We think it's really important to build the evidence base about the needs of people as a whole and also recognizing that this classification is version one and you need to build we need to collect data going into version two eventually.

38:28

I mentioned before we reassessed half the people for four to six months later the dark blue bars in this slide shows the percentage of people in each class at first assessment the like movie colour shows the percentage of people when the same cohort when they were reassessed. so if I go to class two 13% of people were in class one at the first assessment that same cohort was down to 10% of people five months later 3 3 at 4 percent. We're no longer there in that class and the light blue aqua shows the death rate and I'm showing you now the death rates in the same slide. This is really important and I would particularly make a point about the link between this classification and its role in measuring and understanding and risk adjusting quality and safety.

39:40

This is the death the mortality rates by class four classes two and three there are only little tiny groups but they had six and 4% It was like the difference was one person essentially five percent that cohort will die within five months and did within five months. Four classes twelve and thirteen the death rates were twenty and twenty two percent respectively, the classes are not only predictive of cost they are also predictive of mortality and they are also predictive of adverse events your risk of having a pressure sore is substantially higher if you are in classes 12 and 13 then if you are in classes two or three so if you just go off and measure crude Pressures. All right, and you've got a whole lot of people who in classes two and three you're kind of look like you're really good So we've got to be very careful that we
don't create in terms of this sector reform crude rates are not helpful. We need to risk adjust or adjust for the mix of cases complexity adjust.

41:03

We've been testing the classification. It's really useful as a funding tool that's why we developed it, but it's equally important as an outcome measure and that's really important, We funnily enough didn't support report the mortality rate for class one, but the other thing I want to say is to look at the role of compounding factors, the compounding factors almost doubles the mortality rate if I look at pidgin pair 9 and 10. If you don't have compounding factors your death rate in that class is 10% but if you do it's 20%

**Can you explain why there are no statistics for palliative care?**

Because they all died but it's about it's actually because they were really small be little group.

42:01

**How does someone get classed as needing palliative care?**

The current funding model you have an incentive to take the box that says if how you care if you haven't got ten points in another way already in this one if a person is comes in to parody it comes in for palliative care and for those who have the form in front of you our criteria to be getting into that box is that the person has come explicitly in the referral notes to receive palliative care. They have a prognosis of three months or less they've come with a palliative care plan by a GP another primary care provider like a community nursing service or by a specialist palliative care service and they have a Karnofsky score. AKPS of forty or less. It's quite likely if you're really lucky that you will still be alive at three months if you're in that group but the majority we actually already know that and one of the things we do it.

43:05

ASHRI where I work is that we also run the National Palliative Care Outcomes Collaboration (PCOC) so we were actually able to go back through the Karnofsky data to look at 40 in the pilot when we went into a study run. We went in with a threshold of 50 in the final version. We actually lowered it to 40 if somebody hasn't died after a few months in that class and you reassess them they'd end up in class 12 anyway in the main anyway the important issue is that there's n incentives to get people into that class if a high needs person gets into an appropriate class in another way, we're really trying to get the incentives right the other thing of course is that the assessment will be done by an Assessor independent of the care home, but that you have raised an issue around reassessment and I will get back to that at some point, Absolutely Yeah, I will

44:07

I think we think that the tools got three uses and I'll come back to them and I'll when in fact I work them from the bottom up one is to inform conversation about input measures and I've been following with some interest that abate about nursing ratios and when we started a lot of people said all the problem with what you're doing is that you're going out there and you're costing current average practice rather than best practice. I'll return to that in a minute

44:32
The second is to fund outputs and the third is to turn what I think accrued, outcome measures into meaningful comparisons for benchmarking and other purposes that includes informing consumers we need instead of just saying we've got a national quality indicator program pressure sores and physical currency restraint and weight loss we need ways of risk adjusting to get a meaningful comparison in hospitals.

44:59

We don't just go off and measure death rates we actually adjust for the mix of patients if you've got a palliative care unit you're doing debt raw death rates you're not going to look like you do it delivering good quality care but once you adjust for the mix of patients you start to get meaningful comparisons from my perspective a very compelling argument to go to a classification like this is it you've got thirteen classes each of those classes contain people with similar needs for care and where you can expect similar outcomes.

45:37

If you start to report hospital transfer rates adjusted a control to what class people are in falls adjusted for what class, pressure areas adjusted for what class people are in then? You know how you do that in a way that makes sense to a lay consumer. This is like the old my school's website but they can be done and health. Does it all the time and the worst thing that can happen in this sector?

46:03

Is you go from having nothing to having a bunch of crude measures that don't mean anything that then make everybody really cynical.

**Is there capacity for perverse incentives?**

Yeah, well the perverse incentives largely go because homes won't be doing the assessments although they can still obviously have a rolling selection, but you're absolutely right if you do crude measures, then you've really got an incentive to take everybody. That's easy so this is about getting the incentives this is not just a straight accounting exercise to create a funding model. It's much more of an economic model. That's also looking about incentives for good care.

**How can we accommodate the outcomes of the Workforce Transition Strategy with notions of holistic care in this model?**

There's a piece of paper that was handed out and given to everybody and I'd like to explain what it is, It is not in the final report. And nor is it in our slides and the reason for that is because it's so complicated to explain that it wouldn't make any sense and try and put it on a slide

47:10

These are the top section is relative value units all the way through we report our data as other years this is a unit of relative resource use and we might sometimes we're talking about dollars and sometimes we're talking about time but all the way through we will use other use if you look at that. There's the 12 classes I have excluded from all of these costings the palliative care group because there was such a small group we're not confident about the
robustness. We included them for clinical reasons rather than for statistical reasons. Go to the bottom line of the top section and think of these as percentages: 8% of all the time was registered nurses, 4% of all the time the care that recipients received was enrolled nurses, 1% was allied health, 4% was Recreation officers, 76% of all time delivered to her care time for residences personal care workers and 6% other and what people do at that time obviously varies behind that said when you look across the classes and across the care homes as we've been able to do.

48:31

There's some logic order in it in that people receive care time in proportion to their needs and this is really important because it starts to inform those debates about I think just like I think crude death rates or crude Falls fall out of bed rates is really silly. I also think crude nursing rates are very stupid but once you start talking about case-mix adjusted ratios then from both input and output side they start to make more sense. The bottom section is now what are called service weights, so let's take within registered nursing and say the average and that registered nursing is value of one and this is then for class 13 the bottom one on average residents in that class get 68% more nursing than the average and close to the average people in that class get 38% less registered nursing than the average have a look at personal care costs. Personal care 76% of all staff time over, 70% of all costs in eighth this sector are being driven by personal care and personal care is being provided directly in relation to capacity of residents.

50:01

We're now in a position for the first time to have informed debate about what staff profiles should look like and what good practice should look like because now we've got the basis of saying well what is actually the right mix of services that people in class two should get versus clustering.

50:22

The other thing I want you to do is also to look at the pigeon pairs, if I just go to just use personal care at the bottom as an example plus two personal care workers 2.28 for people without compounding factors 0.56 in other words double the amount of personal care time with compounding factors so if you think twice 8 and class 11 are not pitching pears everything else is a pigeon pair and all the way through you'll see that care needs are driven both by the branch of the tree that somebody is in and by the pigeon pairs and those compounding factors do include sizeable loadings for mental health behaviour cognition and so on now I'm not going to say well, I think the right mix of carries for each of the class but it will make a very important point that you now have the sector now has a critical information tool to agree on what constitutes appropriate practice and we haven't had that before.

51:33

People did say to us and they were quite right to say you're going out there to cost current average practice will count. This is current average practice armed with that you are now in a position to start to build the evidence base about what a better practice might look like that said that has to be accompanied by outcome measure because there's a lot of rhetoric about what a good practice looks like in the sector that in my view is not supported by evidence so
I'm going to be very careful that we unpack social marketing from evidence and that we really talk about what is in the best interest of consumers and consistent with their appetite for risk. What I mean by that if we're thinking about what is consumer director care, it's not just do you want a fried egg or a scrambled egg? It's would you? Do you would you do you want to continue to walk independently, even if you've got a higher risk of a fall that for me is what really meaningful measures are and so we need to take that into account as well any other comments on these three concepts of it's to inform input measures not just nursing but all of it. To measure and find outputs and that's what I'm going to talk about but I didn't want to miss the idea that the classification is useful for inputs outputs and outcomes and I think it should be used for all three to get a really if we're going to drive really systemic fundamental reform in the sector. It has to be that we take all three things on at once everybody happy comfortable anybody want to raise issues or comments or questions at this point.

53:29

Was there any alignment with the new Aged Care Quality Standards with respect to the work you have done?

I think now in the next six to twelve months is the time to align them, the quality standards were developed in parallel to this and without there without access to these. They now mean these national quality indicators that have been adopted when they didn't you didn't have a way of standardizing but now the tools are available you know, we don't report crude death rates in Australia, We at least report standardized mortality ratios standardize morbidity ratios in health those sorts of things all the time. We do actually adjust my school's website Does an attempt to adjust school performance reporting to take into account the socio-economic profile the kids in the school? It’s the same concept and I think the sector needs to engage in some meaningful conversation about that.

54:26

Can performance reporting be mapped against the Aged Care Quality Standards?

Yeah, I don't think it's just a simple mapping as part of it, but the other side of it is to understand that crude measures of input and crude measures of outcomes and neither of those are up to the task, if somebody said to me Kathy you run a residential aged-care facility and the rate of pressure sores in your home is twice as many as in Maureen's home then I'm going to say well, of course, I've got the most complex residents, of course, I'm going to say that what else would I say? We've got to get past that to produce meaningful data that will drive improvements in models of care.

It will be important to align recommendations for assessment of care and the Aged Care Quality Standards with the Aged Care Act 1997

Yeah, and I think that's really important work if you go back that we do have recommendations about into an assessment. Internal assessment is not just about identifying what deficits a person's got it's a strengths-based assessment as well, and it's a risk assessment. It's about a dignity of risk assessment. What level of independence does this person Amy? What are the person's strengths? What are their preferences and that's actually start to be part of that equation as well? So that's why I keep saying this is a package I don't see it as a smother's board where and I'm really not wondering I think though a real risk.
These are people go through and try and cherry pick like that recommendation and I don't like that recommendation and expect to get the same outcome. It's a package okay, I think we should this is a really important part of the conversation and you might want to pick up this afternoon. I'm going to now move completely away from quality, and I'm going to move away from outcomes which are probably the areas for us at ASHRI actually as ASHRI runs I think as many people would know the three national outcome centres in palliative care rehabilitation and chronic pain persistent pain so there's a lot of interest in answering in that and also in the assessment area but I am going to move into costing unless there's any other questions about inputs or outcomes. I'm not really going to come back to those again, okay.

56:38

Accountants, here we go. This is yours. Costing AN-ACC funding I do want to make a point and I summarized it very briefly. We did a costing study. It's reported in our third report on fixed and variable costs the fixed care type is the staff time in delivering shared care plus you know Director of Nursing and all those sorts of things. I showed some preliminary results last November but we didn't have our final results in November. Now. I have the final results for the whole of the homes. The variable time is the individual time plus the cost of clinical consumables allocated to individuals we do actually cost incontinent AIDS and oxygen and all that where those costs were allocated to individual but anything that was on impress in the cupboard was just allocated out to everybody equally across all costs direct indirect and corporate eighty seven percent of all of the care costs were direct costs Eighty percent of which is salaries. So what drives costs in residential aged-care salaries? Staff, fifty-one percent of all those costs were for shared care. Everybody gets a share of it. That's all the night staff, etc. In the Director of Nursing 49% is individual care costs 5.6% of costs were in direct admin training insurance, etc. 7.4% of corporate costs were corporate both corporates were mostly the big chains who held workers' compensation and live insurance and all that stuff at a corporate level rather than allocating them.

58:29

We actually got those costs and we did allocate them out to everybody, the key findings in terms of fixed costs the overall proportion was 51/49. From now on I'm not we are we have not reported in any of our reports in dollars quite deliberately. We have reported all the way through in our RVU in relative value units, the reason we've done that is that dollars were last year and now they're out of date.

59:04

RVU some remain in place until you do the next costing study and all you do is you keep updating the dollars and I'll come back to how you update the dollars just get used to the idea that the average is a value of one point zero. So when you see 1.50 costs are 50% higher than the average point eight costs 20% below the average is 80% just think of them as percentages everybody comfortable, okay.

59:34

The major findings remote facilities there is a new classification of remoteness in Australia called the Modified Monash Model (MMM) and the most remote of seven and the most urban is one sixes and sevens. If you're at sixes and sevens it's because you're very expensive
and Jaye opened his comments by saying everyone had told us that 3, 4 and 5s would also be more expensive that was not what we found and we have agreed to do a micro study just on 3, 4 and 5s to try and understand them a bit better. Sixes and sevens are out there on their own, they have significantly higher fixed cost both because that cost them more to buy the same items to provide oxygen, to a remote facility in the Kimberley or in Central Australia costs considerably more than providing oxygen to somebody in metropolitan Melbourne or Sydney and the second is because you have to pay premium costs for staff. The second reason that remotes are very expensive is because of occupancy, we did do an initial look at her home that had 30 beds and three people died in quick succession and I went to 27 beds and the cost of running 27 beds were exactly the cost of running 30 because costs are fixed semi fixed and semi variable. So occupancy is very much related and also indigenous care. Specialization is related as well.

Costing and the way we did this costing study allocated everybody to their case-mix class to their AN-ACC class. Then we looked at the additional costs were left over. We had thought there'd be a whole lot of a cost left over we couldn't account for in the classification for the others that was not the case, contrary to expectations we found no difference in the shared cost per day between specialists dementia facilities and other facilities all palliative care units or called units once we'd allocated people to their class in other words the classification is dealing with those issues and there's no residual cost left unexplained that is not the case in the others so that's I'll come back and I'll show you what that's where we get the six levels from but that's the headline finding.

In relation to the adjustment payment the costs are higher, in the additional adjustment period those costs are involved in getting to know the resident getting to know their family. Organizing your care plan organizing an advance care plan, etc. Etc. Often. People are very unsettled, etc so those additional costs we found that they varied a bit by branch and they also varied a bit by class. Some people tell me we actually knew what the adjustment costs were for every single person, who came into care during the course of the study and when you at class though or in but the differences between the branches and the classes were not sufficient for us to create a whole range of different adjustment payments we've come down on one RVU. The average adjustment period is 16 weeks which is longer than we had anticipated. It might be although I'm sure if you work in aged care, you wouldn't think that was you think that was about right some people of course took, you know six weeks and others took six months, but 16 was the average. We have recommended that it be paid as a one-off lump sum adjustment payment not as a per diem not per day because it adjustment is a lumpy process. This is what the graph looks like for the adjustment period where the bottom line is the average after people are settled and

In the first week on average people who costs are about 16 to 17 percent higher than they become once that they're settled into their class then they go down a bit then they go up a bit and of course no individual actually looks like this this is thousands of people. This is the average of everybody and therefore it's not the real thing of anyone but it does go up and
that's not surprising you know you sit down with a family to organize a care plan or to do an advance care directive or you organize for them to see dentists and sort out their pain or whatever it is. And there's going to be these big lumpy activities the total cost of the adjustment period is equivalent of five days of care for somebody which is higher than our panel had might have anticipated as well, but it's because it's over a long time.

Is there any data on people that come into a residence but didn’t stay?

No, we you've got to understand the way we did our study. We went in turn the cameras on were there for a while. We left again.

How many people came into care that didn’t get into the settling in period?

If somebody comes into care the most reason that they're not there after 6:00 did a very small number of people will leap according to our data the majority reason will be people die and if they die, they're incurring a whole lot of additional cost.

Was respite a contributing factor?

The respites and people are not included, respite is out of scope. And that's one of the areas that we've proposed a further micro study. It may well do so works we explicitly excluded respite.

Do the figures include people that have switched facilities?

We have proposed that the adjustment payment be paid for the first facility that somebody enters and it not be repaid if somebody moves but that needs to be accompanied by a business rule about what information needs to move with a resident from one home to another and homes need to be really pushing that issue we've also said recommended some very strict accountability requirements about that adjustment payment. This is not money to go to the bottom line it’s not money to be contract tasks to be contracted out to a third party provider. This is really genuinely working with a resident to settle them into the home.

What happens if a person moves out of a facility within the first two weeks?

There's a set of business rules that the department may well want to put behind this, you know we're not doing the business rules. We're designing the overall model.

You can make these so enormous, complicated that you'll be back to a 2-inch manual of rules or you can assume that there's winners and losers another will work out in the wash. Can I suggest that everybody take a general approach about winners and losers and working it out in the wash? Rather than let's create 500 rules and immobilize the system up as we've historically done by making it so operationally complicated that said people do need to be accountable for it.

What about relocation stress?

We didn't look at people relocating and that was inevitably going to be the case in the nature of the study, you may well want to come back in your consultation to the department recommending a micro study of people who relocate there's certainly not something we
looked at and would not have been possible and everybody I want to come back to an economic concept of materiality.

67:27

We got to pick up and get the big bits right and worry about the detail later that doesn't mean you shouldn't you should forget the little bit but don't let the system get immobilized by the little bits. Go for the other 90% right? It's not old saying about improvement comes by doing perfection comes later. We really need to get on with reform understanding that there's a set of issues.

**There is an incentive for providers to get their processes right when a resident first joins the facility**

Maybe the adjustment payments should go with them. We really went in and we did a very rigorous study you know, we're researchers, we didn't have the cameras on those sorts of issues but those issues are worth both two things one is micro studies to better understand it where we don't have evidence and the second is some really careful consideration about the incentives.

68:27

**The adjustment period is a good incentive to get the process right for the resident and their family**

The adjustment payment is about making it right for the resident making it right for the family and also genuinely working out identifying those people who could become more independent and also better managing, but some people will come in and they will be very disoriented in terms of behaviour that gives you time and additional money to help those people through that adjustment period any other comments on this one?

68:59

So there's some important issues you might want to feed back to the department in the consultation sheet about the micro detail but again, my advice is that's a really good idea but don't lose the big picture you know you're talking about a very small percentage. Overall, but they're just entertainment is really important and is about driving incentives a good practice okay all the way through now I have been talking about relative value units.

69:31

Which are units of relative cost, so we've got one set of RVUs for the adjustment for the individualized payment for thirteen classes and we've got another set of RVUs for the base care tariffs and we've got an RVU for the adjustment payment now we're putting them all together and creating a new leg a new jargon word for the day that's not it's new to aged care but it's not new to health and it's not new to Treasury called an NWAU a national weighted activity unit where we have waited the individualized care costs the six base care tariffs the adjustment payment and any remaining subsidies, etc and just talking about here's a common currency across the whole of the sector you could have a set of and so you can actually just keep expanding the classification tree and adding other branches and each year, the government's job is really simple they've just got to agree on the dollar value of an NWAU and the rest of the model self populates so now I'm going to move away from RVU’s because
that's about cost. So now we're moving into pricing units and the pricing unit is the national weighted activity unit and the reason I'm waiting it is because there's different costs for the thirteen classes and the adjustment payment, etc. Everybody comfortable.

70:57

Okay, that's in your jargon word of the day the end. Well, here's the base care tariffs and I'll start with, I'll be used first the fix the base character most expensive group homes with an indigenous specialization in MMM in them in very remote locations. Their average cost is four point six times the daily rate is forty point six times more to have the door open. so the average within our use the average is one and major metros in bass-guitar of six a five percent cheaper than the average That's why they've got a RVU of ninety five point nine five five there five percent cheaper Have a look at RVU base care tariff five specialized homeless, They have a base care tariff seventy nine percent above the average. So what's happening in the homeless units is that they disproportionately have more people in the independent mobility classes but they've got much more complex mental health issues substance abuse issues etc that's dealt with in the base care tariffs so 90% of the country is in base care tariffs six and that's because we didn't find any difference other than if you're on if you're not on the board you were no different. We will have no Monty Python jokes at this point, but after so specialized homeless a loading of 79 percent, in MMM sixes and sevens. There's the indigenous is in seven versus six then in non-indigenous and then it's based on occupancy and you'll see the effect so that's cost and that's cost for the actual people in the beds and one of the features of people of the homes in based care tariff one is that they've got very low occupancy and therefore their fixed costs are spread among a smaller number of people

73:24

We have recommended in our report that the base care tariff be paid based on actual occupancy in everywhere other than six and seven but in six and seven it be based on approved occupy funded beds staffed beds and that's why you've got such a big difference up in base care tariffs one so if basically if I use and homie, 30 beds in base care tariffs one if you're funding the full 30 beds even if they're not all occupied then you would fund using an NWAU. If you were only funding the occupied beds and not funding homes for their other beds that they've got sitting there ready to go for their capacity, then you'd have to go up to that higher rate but for everybody else so we've done the difference for those who are mathematically inclined. How do we get from an RVU to an NWAU?

74:30

Well, we did to the NWAU was that there's the 51% 49% split. The other is that the batteries of an n-well one is the average resident in an average metropolitan home that means the dog 2% and then four six and seven, it's based on capacity and for everybody else that's based on occupancy for those who would like more of a lesson on the mathematics and the economic modelling we shall do that at three o'clock this afternoon. Does anyone have a compelling question about that?
Should the RVU for base care tariff 6 be 1.00 instead of 0.95?

What's its one point zero is one there's a should be another line which was all homes one point zero, these are only the ones in Metro and the reason that they're five percent cheaper than the average is that the average is driven up by the ones up here.

The relativity between the RVUs and NWAUs appear to differ across lines?

That's why because for basically tariffs wonderful they're based on approved beds and for five and six they're based on occupied beds and you don't have the approved bed numbers on this slide and while I say approved beds we're talking about staff beds. What so we are talking about what happens in a home? That's staff 30 beds. The one we did was wondering what happens in a home? It's got 30 beds, but three they've got three vacant beds, do you fund the base care tariff based on 27 beds or 30 and what we've said is in regional in remote regions fund based on 30 they have the capacity to have 30 bed but they have low rates of occupancy, but they still need to keep the door open because there's no other facility for their local residents so they have longer periods and vacant beds than Metro.

Whereas in Metro we have funded based on occupancy people in the beds.

What about the relative difference for base care tariff 5?

But the answer to that is because we've calibrated it to the average from metro. Here's the NWAU. Well, so now I've moved from RVU to NWAU. Well, this is the thirteen classes and each resident would get an NWAU based on well not each resident each home would be funded for each resident and n well for their base care tariff at plus and NWAU for their individualized care needs and you'll see what the NWAU is for the adjustment payment because now we've translated everything into NWAU as a common currency language and we've picked that term because the whole of the national health funding model runs on NWAU and it's you insert term that health treasury finance and everybody else is used to and it allows for that same language, the independent Hospital pricing authority IHPA has recently determined the price of an end. Well for next Joe Fitzgerald you're here for me, but do you remember I read it and I thought I must remember what that price is, you just declared it IHPA has determined $5,134 for for a health and while you're not going to get that in aged care but the process can could be similar.

That is there's NWAU's every year and each year upper takes into account the new evidence that's come before it in the last year. That's and you're costing study. It calls for submissions. There's a whole process of calling for submissions issues a preliminary price puts that to a national consultation in October November last year. It's just what the last two weeks declared the dollar value for an NWAU for health that will apply across the whole country and for example, what happens in the Northern Territory is that the number of NWAU is inflated, it's not a different price the price to the NWAU it is the same everywhere but the end markets loaded for indigenous patients for example in remote hospitals so that's what the classes look like and you'll see that admits of pal care class 1 and class 13 are the same so if a
person ends up being at the end of their life once they're in care they would be reassessed and they're not being class 12 or 13 or whatever it is Anyway, so that issue about getting people classified as they walk through the door is not an issue anymore

79:17

In the in the reports which you haven't yet seen we used a working example of a imagine the government set an NWAU of the hundred dollars, this is what it would look like and we did that just because one hundred dollars is easy and people can generally multiply it by you not because we think a hundred dollars is what would be paid, for which we can all be grateful when the Prime Minister made that recent announcement about the package of additional funding for the sector. In that statement was a statement that said the average ACFI payment per day was $172. So if you just took the money that's currently in the system and you distribute it this slide shows what it would look like. So if I use class 13 and the reason I'm doing that is because I'm not very tall but if you use class 13 for people who can't mobilize, low function ADL’s or risk of a pressure area and with compounding factors and that person in the most remote facility would be paid four hundred and eighty-two dollars a day and you know homeless facility three hundred and thirty one dollars a day and in the major metros two hundred and fifty seven dollars and the job of government every year is to determine the dollar value of an NWAU.

80:49

In the way that and what happens in health is that the role of the Independent Hospital Pricing Authority is to be the independent body that determines the dollar value of an NWAU, I'm not saying that should happen here. But I'm saying the task is a lot simpler then what happens now, we're subsidies. For example because then you've now got your ACFI prices and you've got your subsidies and you've all that sort of stuff what this means is that things like the homeless subsidy no longer exist but if the NWAU goes up, then there is automatically more money rather than subsidies being separately considered so it's really simple compared to what people are used to its conceptually I think I'm happy to say much more sophisticated but it's administrative are simple and then what the sector’s been used to and I think we have many - a lie the fears that were in the sector that we were going to come up with a Classification that was much more complicated and had 100 classes and bla bla bla So any other questions on that before I move on questions or comments? Actually, that's what the whole model looks like together and if you used 172 dollars because that's the and that was the dollar value that was in the press release then the adjustment payment is nine hundred nine dollars.

82:26

**Who sets the price of the NWAU annually?**

We've got some recommendations in our report now, so I'll take you through what they are essentially there's a there's a couple of ways things you can do one is you can take way or their seconds you can take the easy way at it's worse. You do what some of the states and territories have historically done which is to take last year's price and add a bit for CPI a more sophisticated approach is that you do an annual costing study and informed by that you take that into account in determining the price. You also do things like IHPA it but determines the price and they don't call it the national average they call it the nationally efficient price the
NEP and they call for submissions on changing models of care and in health, that's quite rapid, you know new anaesthetics new drugs, etc Will determine the price. We have recommended an annual costing study and one of the ways you can do with an annual costing study is simply just calculate the new cost for an NWAU but the other thing you can do in costing studies is to look at the relativities between the classes and you can say well we only do a relative cost. We're doing a costing study of these. We're happy with these six tariff classes, but we think the relativity's have wrong now something's happened. That means that this we have to change the NWAU relativity's between the classes.

**Can costing studies be undertaken to accommodate new models of care or new technologies?**

so when you do costing studies you can simply just determine the dollar value of an NWAU or you can do for example a nursing costing study. We've done that nursing service. Weight costing studies in Health quite routinely to recalibrate the nursing weights for the classes or you could do an allied health costing study best practice costing study and say what should the weights look like in the classes so at its grossest you could just do a let's calculate the dollar value of an NWAU but if you've got the right information structure and we're very happy to say we think this is the right structure, you can start to do the sorts of studies that are really important what is the best practice distribution of Nursing costs or what's the right ratio between personal care and our ends and ends or whatever question you got.

84:58

You could make it as complicated or as simple as you like as long as you've got the arc the architecture, right the other side of that. This is version one of the classification in acute care the diagnosis related groups system the acute care changes quite rapidly. There is a new version of the classification pretty much every two years we developed the Australian national sub acute non-acute patient classification the snap classification that IHPA also uses it is the national funding model for sub acute. There's only been four versions of that classification in 20 years because models of care haven't changed as much but we have changed some of the cost weights over time that in the end. We're over time to reflect changes in technology but the technology changes aren't as rapid we have recommended.

85:57

Normally you'd say in this sector. You wouldn't do another costing study for a couple of years but because there's been a lot of concern that care is being models of care are being perverted by the incentives in the ACFI, We have actually recommended that there be another costing study a year or two after rolling the out to look at revitalizing the classes when the incentives in the current model are no longer being seen in the models of care delivered on the ground that said if you go back and have a look at these results they absolutely pass the pump tests look at personal care down the bottom people are receiving personal care in proportion to their capacity and you can go up and do another costing study or models of care study and it's very unlikely I suspect to change the relativities between the classes. I've seen people do these appropriate care studies and lots in other sectors. It ends up not changing the relativities between the classes but it can you know, there's been if you think about issues around how do we manage you know the use of chemical restraint if we start to change that that starts to change relativity's between the classes.
How have you classified nurse practitioners?

In nurses or RN’s I do want to make her I'm here. I will call on the economic or accounting principle of materiality

87:31

Have a look at these sheets 76% of all staff time is personal care workers and 80% of all cost with staff, we can we can make the conversation about registered nurses and personal care workers, you know clinical nurse consultants and nurse practitioners and no specialist as much as detailed as you want and alright, we're talking about how to 8% the care costs are being driven by personal care.

What about the low wages of personal care workers?

But I do think the importance now is in having an architecture to inform those sorts of conversations and it may well be that having I mean I think the really good thing from my point of view is care is not being randomly delivered out there. I was involved in the first-ever national mental health classification study on I had a quite fear for the whole study that we might find the care was being randomly delivered. It's not people are receiving care in proportion to their care needs people are taking the resources that they have and distributing between their residents in proportion to their need and we could do a whole lot of sophisticated work, but I suspect that the relativities between the classes wouldn't change too much but would be interesting to Tammy nods in academic that's the sort of stuff I would prefer to do but that'll be I guess I'd come back. Everybody's got to learn to walk before you run this.

89:16

Represents a seismic shift in culture and in the use of evidence in this sector.

How often are residents reassessed?

I'll show you what the recommendations are for reassessment. I'll get to that right now so just to just to summarize before I move into recommendations. We do have the 13 classes. They are based on capacity one of those is for palliative care to people who are independently mobile and then five each for assisted and for non-weight-bearing and that is in proportion to their representation in the sector and I think that for me is actually the first really key finding that's important this is a very frail population. It is a much frailer population than those who work outside the sector often perceive it to be it is this is a cohort with very high clinical needs as well as social and We really have to get past the idea that we're talking about this is somebody's home as though residential aged-care is a lifestyle choice and start to talk about the care needs that people have social emotional and physical.

90:39

The second is the tool we didn't start we started off personally being dragged into internal versus external assessment when we first started the international research on this a couple of years ago. We have come down very firmly that you have to split assessment for funding from assessment for care planning. Assessment for funding has to be done externally and separate from assessing what a person needs wants and aspires to and I think we've got a significant problem in the sector because the individualized needs and strengths and
aspirations of residents are playing second fiddle to the funding model and we have to change that in order to change the culture. The other side comment I'd make about the external assessment workforce is we got great feedback from the Assessors we used and a number of them said they would actually return to the sector that they had particularly the are ends that they left the sector because of the paperwork burden of what how they spent their day and if we liberated them from the burden of paperwork they would actually return to the sector to do what they want to do, which is to be an RN.

92:03

So I think that's a really important workforce issue the third is the funding model with the three elements the base care tariff, so every resident gets one adjustment payment plus per day a base care tariff and an intact payment. It doesn't obviously go to the individual it goes to the home but it starts to shape that conversation in more sensible ways I think the other issues I would want to say is about this starts to deliver better data to understand the needs of residents in the sector in ways that the sector has not been able to articulate until now I do not think we should underestimate being able to demonstrate how care needs change over time. This is a much more dependent population than it was a decade ago it is quite likely to be a much more dependent population in five or ten years than it is now we need to be able to systematically measure that to have the evidence base to argue for what's needed.

93:14

The last issue comes back to that one about outcomes if reassessed if the classes contain people with similar needs then you can use the classes to adjust quality and outcome measures in much more meaningful ways hospital transfer rates adjusted for the class that the persons in rates of functional decline adjusted for the class that somebody started in rates the functional improvement adjusted for the class that somebody started it rates of adverse events falls medication errors and injuries etc adjusted for the class that somebody's in you do not want to create the funding model that creates incentives to take low need residents over high need residents. We have to understand that there's a cohort that are very high need they are also the cohort that are at highest risk of adverse events and therefore that needs to be reflected in the funding model so it's about both having a meaningful measure of that cohort, but also a meaningful payment model that recognizes the additional needs of that cohort. I'm about to talk move on to modelling the results but are there any final comments or questions on that on the actual results themselves before I show you what the modelling looks like.

94:47

**Were any residents under the age of 65 excluded?**

I'm about to show you in the modelling. Okay, we did model the results, this is a whole report on modelling. It's not very detailed, we were looking at whether there are systematic differences across the country by sector in states and territories, but also looking at things like demographic features called residents at sea resident’s young younger group, etc this shows you the twelve classes again. We've removed the palliative care group for each person we assessed in this study we actually knew the amount of dollars that they were getting in their ACFI and we converted their dollars XE dollars to relative value units for comparison purposes. So we're comparing like we'd like so the red shows you what a person in class 13 would be getting the average per person in class that in the average over you is one point six
nine or 1.8 up the top there. What you can see is that the AN-ACC with its 13 classes is differentiating much more paying a lot more proportionally for the high need end. What's happened with ACFI over time is that it's sort of stabilized and everyone sort of being paid the same so under this model people in the more independent classes actually get funded less, don't forget this is only the individualized side. There's also a base care tariff and that solves issues like the homeless facilities you've got more people in the home. I'm just looking at that, you've got more people down here but then you add the 79 percent premium on the other side and there's squares out in the wash you actually come out as the single grip that actually fun get funded more in our RVU terms is actually how people in homeless facility and I'm betting to show you that next but does that make sense to everybody so what it's doing is that there are people who are classified under the ACFI. High, high, high in every one of our classes because the ACFI is classifying people into high, high, high and are various other classifications based on a whole lot of things other than their needs so it's not differentiating well and therefore it creates financial penalties to take hi need people this is aim to correct that in terms of perversity by paying homes more based on the care needs of individuals in those homes. Everybody comfortable with how you're interpreting the slide comments or questions.

98:11

So from our point of view we aimed to achieve that we actually aimed that care home should be funded more for high need people so we're quite happy with that. Not everyone necessarily will be of course depending on where you start now. This is a summary of what the impact is facilities in our modelling study self-identified, for those facilities that said they were a specialist called facility or a specialist dementia facility. There's no impact. There's no difference. You will see for the homeless facilities up here they would receive considerably more than they're currently receiving Michelle. You asked the question about the under 65, within terms of age groups the 65 to 80 for the 84 pluses are about the same 94 plus is just a slight bit reduction that the big difference is actually in the younger group. That is picking up the homeless group. It's also picking up the young onset dementia and a range of other things is which is exactly what you'd want to do. I think because they've been identified historically is the group that are not being reasonably assessed so the groups that are the major this is all about proportions but the group who were assessed as being higher need in this funding model then in the current model. People in homeless facilities people in the indigenous facilities and people who are younger and then when we get down to individuals, the interesting thing about the people who identified as preferring English as a second language is they are actually higher need but the ACFI is already recognizing that quite well and I think that's about entering care later in their lifetime When they are more dependent. Comments or questions any surprises there or any concerns there?

100:39

What will be the impact on supplement funding?

Yep, I think there's two issues the first is the structural issue one of the problems that people have who've argued successfully for supplements is that often rates overall will go up but the supplement won't or you'll have a separate fight what we've done is we've calibrated everything to an NWAU. So if the end well goes up everything goes up so in terms of structuring you into the future and you're better off. The second is that you do actually end up
even with that it included you end up being better off but I think the more important issue is as much as possible. We should be aiming to get rid of supplements and roll it into the into the payments so that if there is an increase in the end where price it flows on through the whole sector, rather than some supplements going up and others not and getting out of alignment and those who lobby the most get the most and all the things that have historically happened.

**How does the proposed model impact on facilities that specialise in dementia?**

They square off they're but when I say there's career after I score off in terms of the average there are some that will make a lot more money and others that will make less but of course it all depends on what the dollar value of an NWAU weights. Right we've modelled when I just showed you is we model 472 But the issue is not just about the quantum it's also about the distribution we will not achieve fundamental the necessary fundamental reform in this sector simply by increasing the quantum. We actually have to improve the funding model and then do something about quantum as well. That's the second side of it but the quantum alone won't solve the problem. This is the class structure, so go back to my 12 classes you might know you might actually find it easier now to go back and look at the list of classes in the earlier in the presentation. This is by age group, but I will just remind you that classes 2 & 3 are the independent branch to being the independent branch without compounding factors the orange being the independent branch with compounding factors

102:57

The next five classes 4 through 8, which is gray through blue is the assisted so there are some differences and that is not at all surprising the important issue I think here is the face validity of this it makes absolutely perfect sense that this is what the profile is that the younger group the other thing to say about the younger group though is that they actually have a sizable proportion in the non-weight-bearing all group This for me is a really interesting slide this is what the profile looks like Just be noticing the number that we assessed in H state and territory. They're a little bit small in some not small, but just in terms of drawing too many conclusions for the Northern Territory in particular a CT we are we swung in with you South wealth because we didn't have enough there for a meaningful report on their own.

104:04

**Does South Australia have a greater number of residential care facilities than home care?**

I do want to put point out South Australia, South Australia has the highest need population in resi care in the country and it is quite different to the other states and territories. South Australia has less than 5 min. I said 15 percent of people are independent immobile in the sample. We did in South Australians 5%. We think and I will give you a little in separate work I do which has got nothing to do with this project but at the end of last year, I was also doing a project looking at hospital death rates around the country and in all states and territories hospital death rates of 50% 50% of people who died in each state and territory die in hospital except in South Australia where the hospital death rates 43% I think what's happening, I'm not sure but this is where a really important study should be happening.. I'm thinking it looks to me a lot of people homes in South Australia keep people longer don't transfer them to hospital and they take people later in keeping them longer and keeping them
till death probably have a hospital or higher in home death, right? I don't know that though but it certainly makes sense.

105:36

So this one was a bit of a surprise hasn't yet has - not a lot a whole lot of people in class five, so they've got people who need assistance with mobility but with other compounding factors, and I think that might be people that's about the configuration of health as well. So all of a sudden you're starting to talk about what's the configuration and what's the interrelationship between long term health requirements, brain injury units for example some of what you're seeing here, of course what we're showing you because I'm showing you in one graph at a time is not picking up the sophistication of the interactions if a state or territories got a whole lot of younger people or a whole lot of homeless people The holo called if you go back to those other factors that's being reflected here in a summary statistic We can only tell you what's happening people in the sector can universally tell you why you think it's happening then the question is is that something we should actually be exploring in some more detail. We've certainly had some speculation among our group about why is that the case I'd be interested to hearing from the South Australians so the stories already said always said you had a higher more dependent population. South Australia that is the other side of it South Australia and Tasmania are our two oldest populations in the country but if that was the case if there was less homecare, they should actually have a more independent population because the threshold to go to resi would be lower. Maybe there maybe they've now got more options for people to stay at home longer.

**Has South Australia been running a program to support care at home rather than in hospital care?**

Yes, we've been doing some work not as part of this study but as part of the palliative care outcomes collaboration the National peacock that around and we're estimating that in a lot of regions. It's a hospital deaths right from people living in residential aged-care is up around 50%, 50% of people in a lot of regions are being transferred to hospital. Well, not so I think for the first time and that's why I'm saying I think we shouldn't underestimate the importance of putting this sort of evidence on the table to start to understand why my team went in we turn the cameras on we did a I think a pretty good job turning cameras on and we know what happened but that doesn't mean we can understand why things happened. I think people in the room have a lot more understanding about why you think things happen but I also think it starts to generate a very long agenda of research and development agenda or indeed gender about these are the studies, we now need to do to better understand what's happening across the country in terms of access and equity as well as quality and cost. We've really got to get all those variables right.

108:50

Okay, here's the next one this is looking at the three big sectors. This is the government the not-for-profit and the private for-profit sectors, again you'll see there are some differences. The headline message is that the government sector has the most dependent people I don't think that would surprise most people we we've certainly had got a little section in our synthesis report about the need for explicit policy on the relationship between cost and price but I'm really clear in the work I've done beyond aged care that you don't actually want to
create incentives to cherry-pick some classes and not others that is not in consumers interests or the communities interest so if one of the outcomes of the change is that you have neutralized, the incentives to cherry-pick then that for me would be a very good outcome in terms of me as a taxpayer but we're starting I think to start to unpack those issues in ways we haven't been able to unpack before anybody else want to comment on that one before I move on because I'm now about to walk you through the recommendations we won't get through all those after before lunch, so I'll pick up the rest after lunch, but I'll give you a general flavor before we break.

110:34

There are 30 recommendations, this is the basis of the afternoon's conversation. Some of these are very self-obvious and I won't waste time on them. Some of them. I'll just say hold your comments to go through for the afternoon because the Department will be seeking in the afternoon session feedback instruction not about all 30, but there is also a consultation process, etc. I'll charge you do them in sections, but some of the recommendations are covering material I haven't covered so far so I'll focus on those.

111:10

The first is the obvious one is we think this classification is ready to go, We think it is sufficiently robust, it's statistical performance is actually better than DRG now that doesn't mean it can't be made better in version two but the way to improve it is to implement it and then diversion and when I say DRG I'm talking about medical DRGs but the statistical performance is very good and there's two and a half times better put statistically than the ACFI so we're very happy.

111:48

The second set of recommendations two and three are around the tool. We think the tool is also ready to go, we think it should be adopted as the national standard funding assessment tool. Recommendation three says everybody who's new coming into a care should be assessed plus or minus four weeks. Four weeks before they come in or within four weeks of being in and the assessment is about capacity not about what they're doing on the day.

112:28

Number four says people requiring reassessment be assessed using the same tool by an independent Assessor as well. There had been an initial conversation of would it be possible to have a system where the initial assessment was by an independent but a reassessment was by the home we have come down saying it should actually be an independent Assessor all the time.

112:55

The fifth recommendation is that aggregate de-identified data be published as an annual report on the needs of people in this sector that is very important to put in the public domain. What this sector looks like and the changing needs of the sector, in relation to reassessment we have made three recommendations we did do the reassessment study and we looked at all sorts of things that happen to people between we got the homes captured for us all the things
that happen to people between reassessments those who went through real mint programs those who fell out of bed those who got sick and went to hospital, etc, We've got three reasons to reassess one is that the person has had a significant hospitalization it proved to be very predictive of a change. It's efficient to move people to in your class the threshold we used is that the person's payments would change by 10 percent or more, we are set the threshold quite high we do not think it's in the interests of the sector to have a whole system geared around looking for opportunities to reassess. If everybody stays in class three and you're doing that and you're costing study the next year and they're all in class three the NWAU will go up. You don't have to move. Everybody do a new class if everyone's a little bit frailer so this issue the reassessment protocol has to be considered in the light of the decisions around and you're costing study those sorts of that's why I'm saying this is not a smorgasbord It's a package. The NWAU for the class can go up if everybody gets frailer without everybody getting reassessed to put them into a new class so increased needs as indicated by a significant hospitalization we have defined that in the report but it's essentially six days if it's a medical admission and two or two days with the general anaesthetic if it’s not so those the people who came back having had either of those two things mostly needed to go to a high paying class

115:18

The second reason is that they've moved from one branch of the tree to another the person the homes would speak this the person is no longer independent now goes to assist in mobility or go is no longer assisted mobility is now bed-bound. The third is that if neither of those things have happened but they will be the majority of the reasons. If neither of those things that have happened then the clock has ticked on twelve months for the classes with the low mortality rates and six months for the classes with the high mortality rates the seventh is that we're really concerned about the reassessment culture in the sector and we have to break that culture. It cannot be a sport that everybody goes looking for an opportunity to trigger everybody for a reassessment so there should be the capacity for the Commonwealth to charge homes for triggering unnecessary reassessment recognizing, of course that somebody could be reassessed and go to a lower paying class as well I think the reason we put this in is make a very explicit recommendation about culture about changing the culture in the sector the recommendation 8 is a really important recommendation there be no requirement for a reassessment the home makes a decision about whether the person needs to be reassessed that means that all the compliance functions and all those things currently in the system would or disappear. You would no longer do that that would be a considerable cost saving to the sector considerable cost saving for government for reinvestment but it is explicitly about solving this issue about perverse incentives I mean look the reality is the majority of people are very frail at the end of their lives within a few years and are going to have increased care needs We do not have a pope profile of a group of people who are preparing for the Olympics, we are that said there are people who are coming into homes who've been struggling at home and I've had malnutrition have had severe depression have had really bad teeth and haven't been able to eat all these sorts of issues if you sort that out during the adjustment period then they win and you win, so recommendation 8 is also about making sure that the incentives for quality and outcomes a big number nine and ten are saying that we have a recommendation that there needs to be an investment in the best practice and needs identify identification and
care planning assessment tool should be developed based on best practice guidelines and
provided to homes and periodically updated.

118:31
That is solely about help for care planning purposes with the resident ear completely separate
from funding. The next is that as a condition of subsidy every carer with their family
undergoes and at least an annual assessment okay in terms of the so that's assessment, I'm
now moving on to the funding model and I've got obviously want to make a comment about
these we have made thirty recommendations and I'm running this rhythm. It will be up to
government to accept these recommendations or reject them if they think we've got it wrong
and you may think we've either got it wrong or them you need to add some or you want to put
conditions on it but this is for us a package largely, so now I'm about the funding model
we've already talked about this the subsidies payable to the homes big consisted with three
elements each of which is calibrated as an NWAU but there be a specified table of base care
tariffs reflecting the structure I showed you the six that we've got the base number 13
Recommendation that homes in remote areas six and seven be funded or based on approved
beds capacity with all of the base tariffs being raised based on occupancy. I would make a
point that if government didn't accept that recommendation the n-well would be need to be
recalibrated because we have calibrated on the n-well on the assumption that that
recommendation is accepted 14 obviously is that people be paid for their class and we've set
out the tariffs and the classes and the end wells in report 6 as the first version. We have been
very strong in trying to make a point about this is not set and forget don't think you can do
version 1 and in 20 years’ time somebody offered do you think it'd be a good idea to Division
two. This needs to be a dynamic evidence-based approach that's about culture and about
investment.

120:59
Recommendations 16 and 17 are around the initial class that's no different effectively to
what's happening now except that we're very explicit about it. We’re not wanting a model
that's about cherry-picking eighteen and nineteen are around the adjustment payment the
adjustment payment is 5.2 a then well so in other words 5.2 days of care, that's a lot.

121:37
So the next recommendation says this should not just be added to the bottom line and it
should not be contracted out to third-party providers we are not supporting the emergence of
a new industry where somebody comes into your home and does this is to be consumer and
family focused and so it needs to be done by the home and by the care providers who will go
on and deliver that care in terms of twenty we've got a set of common recommendations
around the subsidies. The first is that the homeless supplement and the adjusted subsidy
reduction be discontinued and dealt with in the base care tariffs, etc we have said four there
are still some people in the system who were assessed in the old and they're still being funded
by it but it's time to end that grandfathering around grand parenting arrangement and reassess
them and that all of the others we really weren't confident, We had enough numbers to be
confident about those so we have said grandparent everybody who's a current recipient and
do a series of micro studies, really trying to understand those and how to deal with them. But
whatever the results they should be dealt with is it well not a subsidy table this represents a
significant practical and culture change for the sector. We are recommending that it be that the Commonwealth developed a national transition strategy that progressive implementation occur over two years and what we mean by that is that everybody currently in the system gets grandfathered and parented in the way that they were in the past all new residents be assessed with an AK and then after 2 years anyone still in the system then be assessed in the next 6 months. So we don't want to leave it open-ended like us. Yes but we don't want to have ground held day where everybody moves on the one day We do think that the way to do this in terms of managing financial risk is the concept of a stop-loss threshold that where people are guaranteed at least 95 percent of the money. They got the year before so the most home could lose is 5 percent that inevitably involves treasury providing an extra quantum of money for the transition period that may not use it but we don't want to see providers go out our modelling is that in fact, most people wouldn't even get anywhere near the 5 percent, but some might It's some of you know might even get 7 percent or whatever, but that's an important part of it the stop-loss threshold is part of the package and with transition payments were in hospitals and states of move with states and territories are paid.

Transition payments with a very in a very similar sort of arrangement that's why this is a whole-of-government response because we think that the stop-loss thresholds are really important part of it, obviously we recognize the importance of this in the need the size of the effort that the Commonwealth's develop a national implementation plan 24 represents a significant change health has just finished its show you might correct me 24th annual hospital costing study 22 okay for 22 years this country has invested in an annual costing study in hospitals and in 22 years we've invested in us one study in aged care so you're 22 years between behind the health system in understanding the relationship between cost and funding and price. We think that needs to be an annual costing study at least to start with after a while It may be that it goes to a net, you know a biennial with submissions and CPI on the alternate year or whatever but it there needs to be an annual costing study at least to start with and each year informed by that the Commonwealth determines the dollar value of an NWAU and then the whole model self populates. We have actually give the Commonwealth the model in an Excel spreadsheet because you can do that run the whole model in a spreadsheet because it's simple enough.

In terms of the assessment workforce, we are mindful of other recommendations arising out of the tune report and elsewhere about reform of a cot and races and all those sorts of things. We have no view about that we do have a view though about there needs to be a national network external assessment model and it needs to involve the credentialing of individuals rather than agencies. I'm quite happy to see an AN-ACC assess a credentialied assessor in an akaps or in another sort of organization. I don't care what the organizational arrangements are. We this is a highly skilled task to assess capacity, those people need to be credentialied. We have tested and we are confident and we are limiting our recommendation to registered nurses physiotherapists and OT’s who are credit undertake training are credentialied and participate in ongoing professional development, How that fits in the broader assessment Workforce is really a bigger policy question for government, and we're outside our role. Does anybody want to comment on that one? Would we worry that one?
Are dieticians, speech pathologists and psychologists included in the proposed external assessment workforce?

No, we have limited time but what we did was we really went back and we looked at core training where there are individuals, I'm a psychologist. I reckon I could do an AN-ACC assessment. I'm not really a psychologist I would be registered that people used to go back but there are individuals who could clearly do it but when you look at the core competencies of what our dieticians or you know social workers or psychologists we cannot assume that the core competencies which are around function frailty capacity those core competencies are built into the competency training, For the nurses the OTS and the physios it may well be in time that people want to expand it beyond those three disciplines they are the only three disciplines we are recommending in for the first phase of implementation, but when the core of the classification you get into three different branches of a tree based on your capacity for mobility. I want professionals who've got core ability to assess capability to be the core of the assessment workforce so accountants you're out. So the requirements we're talking about other people are credentialled as individuals so you would talk about accreditation of agencies and credentialing of individuals. So that's how we're using that language credentialing of individuals there are OTs or physios only they have to have experience in aged care they have to complete approve training and they have to comply and with continuing professional development requirements.

Well, the way we supported the workforce in the study was that we did teleconferences with a national assessment workforce every week people brought forward cases that people that they'd assessed and we did that they had difficulty with and we really work through. We did a whole lot of help agreeing on the rules for truck for that about how to assess. What do you do about this will that. We want to get we want that to be a level peg field around the whole country. The other thing I would say about that our assessors gave us anecdotal evidence at the end that they felt that if the person was set up properly they could do that assessment via videoconference from a remote, Australia. We tried to do that, but the logistics worked against us actually testing that so it wasn't tested but our assessors felt that if they had somebody who was in a home or in a hospital or whatever and they had an RN with them and somebody was assembling the paperwork and all those sorts of things that they could do that but we didn't get to test it just at the timetable we were working on was just too tight that's the logistics of doing that is really quite complicated that said that's a really important issue from remote, Australia. The Commonwealth obviously needs to sort through the RTI issues. I cannot underestimate the need for recommendation 28 well when I talk about the Peaks, the peaks. I'm including not just providers but consumer groups as well and the peaks. Okay, yes, okay providers, please note that 28 includes the peak consumer representative groups as well we assumed that

The last two are really a bigger picture issues one says, there is now a need to commit to an ongoing R&D strategy for this sector this needs to be an evidence based sector that is driven by the best available evidence and where models of care are developed and refined in
response to the available evidence. I come from a health area where I've been doing health research for more too long and when I think about the culture differences between those sectors, there's a long way to go, but the best time to start was last year, the second best time to start is this year? And the worst time to start is next year. This really has to happen.

132:54

My last recommendation is also a big one that some other muggins not us but we do think these same concepts work equally well in community aged care and that having done this piece of work there now needs to be the equivalent study to develop a case-mix classification and funding model. It can be that there are separate branches of the AN-ACC tree. Classification tree added that could be for rest spot. It could be for transition care. It can be for community aged care whether it's packages blah blah blah, but that the same issues relevant to community aged care and in fact if you don't do that you'll have the same issues in community aged care the idea that you've got for package levels and then with really heterogeneous needs in each package is exactly the same issues that we're now dealing with Many years later in resi care on that basis. It's time for lunch and I'm handing back to Jaye.