



# AGED CARE INDUSTRY COUNCIL

Peak Council of Australia's Aged Care Providers



## MANAGING THE ACFI – INDUSTRY ACTION

The introduction of the ACFI will have some positive and negative impacts for aged care providers.

A number of issues have already been identified and raised with the Department of Health & Ageing. Refer Table 1 for details.

There will also be a need to monitor the impacts of implementing the ACFI on residential care provision and funding.

ACSA will be monitoring impacts and will require your assistance to do so effectively. There are a number of areas we are particularly aware may have a negative impact and your support is required. Refer Table 2 for details.

Information on this will be updated regularly and can be downloaded from <http://www.agedcare.org.au>

**Table 1: Issues Raised and DHA Initial Response**

ISSUE	DHA INITIAL RESPONSE
Q1. Nutrition not including fluids.	User Guide to be amended to reflect that it is a valid claim.
Q4. Toileting support for bedfast residents can't be claimed.	User Guide to be amended to include other materials in the definition of a valid claim.
Q6. The PAS tool suggested identifying the limitations of the tool.	DHA looking at replacing or providing alternative assessment tools that can be used eg RUDAS and KICA
Q11. Medication management. Request made to DoHA to include crushing as part of giving medication.	DHA considering including crushing at the bedside. Guide unlikely to be changed in short term.
Complex Health matrix modelling needs to ensure that low care residents can access this domain.	DHA considering this point.
Pain management not reflective of best practice but narrowly focussed interventions.	No response at this stage.
Can make a higher claim if allied health staff are involved with a pain management program. Not all facilities have access to allied health.	Being considered for future action.

ACAT reassessment issues for residents admitted as low care but are assessed as high care under the ACFI – time taken and financial loss	DHA considering removing the requirement to assess low to high. Unlikely to be action in the short term.
Need for consistent terminology throughout documents (eg major/significant, domains/supplements)	DHA considering this request.

**Table 2: Ongoing Monitoring**

<b>AREA</b>	<b>MONITORING REQUIRED</b>
Behaviour Management	Monitor the impact of the focus on funding for cognitive behaviours, ignoring behaviours that are related to a physical condition, and its impact on funding.
Admissions direct from hospital	Monitor the need for the 6 month review.
Removing interventions because of resident improvement	Monitor industry and validator behaviour to ensure funding is maintained at the assessed level.
Moves from Medium CHC to High CHC due to end of life care	Monitor what triggers this move to assist providers identify and claim higher supplements for end of life care.
ACAT assessment of high/low care	Monitor behaviour to see if there is a reduction in low care assessments with a consequent impact on bonds
Validation process	Monitor process to ensure it doesn't slip into the RCS mode of checking interventions rather than assessments.  Industry submitting more information than required for validation.
Classifying frail residents as 'high' on ADLs	Monitor outcomes in practice and seek adjustment if required.