AGED CARE INDUSTRY COUNCIL

Peak Council of Australia's Aged Care Providers

TIPS & HINTS FOR MANAGING THE ACFI

The ACFI is now operating having been introduced on 20th March 2008. The Department of Health & Ageing has provided documentation and guidelines to assist you to implement the ACFI in your service.

The ACSA Federation is however aware of some areas that may not be clearly explained by the documentation or may not be obvious when you first start undertaking ACFI assessments.

This tips and hints sheet has been designed to supplement, not replace, the material you receive from the Department. We trust it will be a useful tool in the early days of ACFI implementation and provide support to you and your team as you work with this new funding system.

A Q&A section will be set up on the ACSA website (agedcare.org.au) and will be updated regularly.

ACFI Assessment Questions

The ACFI is made up of 12 questions and the appraisal pack provides information on how you are to complete the assessment. ACSA has noted some additional points you may find useful in undertaking the assessment.

Question 1: Nutrition

You can claim fluids/supplements as well as food under this question.

Question 2: Mobility

When completing this question you do not need to record the number of people providing physical assistance. You only need to record that there is a need for physical assistance. Physiotherapy assessments may be useful evidence of care needs in this area.

Question 3: Personal Hygiene

This question requires you to assess whether verbal & physical assistance is needed to support the resident's personal hygiene. The question to consider in completing this part of the assessment is what would happen to the resident if a staff member wasn't there ie. they wouldn't take a shower or would have difficulties in washing and drying themselves. The need for assistance or supervision is the most important aspect and that's why you can claim it.

The claim is supported by the medical, mental and behaviour diagnosis and assessments.

Question 4: Toileting

Assistance with use of the toilet, bedpan or other toileting materials (eg: a "Bluey") can be claimed.

Question 5: Continence

DHA has suggested that claims for continence require hourly observations. ACSA suggests that services will be unable to take this level of observation and that as long as it is observed/monitored at least 2 or 3 hourly during waking hours the claim will be sustainable.

Question 6: Cognitive Skills

Currently the ACFI appraisal pack requires the use of the PAS tool which has limited application for residents from CALD and indigenous backgrounds. You can use other tools where you have a client population that would benefit. Other tools suggested include the RUDAS and the KICA (Kimberly Indigenous Cognitive Assessment Tool)

In your ACFI assessment you will need to explain the reason you have not used the PAS and should include the other tool in the ACFI pack. Your decision on the rating will have to be made on the definition in each of the ratings.

DHA is also aware that you cannot use the PAS for residents with frontal lobe dementia and this will be included as a reason for not using it in the list supplied in the guide.

Medical diagnosis of dementia is required. Medical diagnosis can be obtained from a GP, the ACAT assessment, CMA, medical notes or clinical reports.

The medical diagnosis must also identify the person who has documented the diagnosis and the date of diagnosis.

Questions 7, 8 & 9: Wandering, Verbal Behaviour & Physical Behaviour

These questions need to be answered accurately and staff need to understand the definitions for each of the codes for each question and what they are looking for to justify the claim. The ACFI Assessment Pack (pg 6) is very useful in assisting with the understanding of this question. It is suggested that this page be displayed in areas where staff complete records.

ACFI high behaviour classifications are related to cognitive issues rather than a condition or physical cause. Depression may be a cause of some behaviours in chronic diseases such as MS and Rheumatoid Arthritis.

To be eligible for the High behaviour supplement you must have a diagnosis of dementia, psychiatric disorder or behavioural condition.

Question 10: Depression

The Department has identified that some of the behaviours claimed are symptomatic of depression such as withdrawal or refusal of care but no Cornell Scale has been carried out and there is no claim in the question for depression. Staff will require detailed training in the instrument as it is not an easy tool to use and can make staff feel very uncomfortable in asking some of the questions.

Medical diagnosis of depression is required. The diagnosis may be done at the time of the ACAT assessment and will be documented on the ACCR. A GP assessment and diagnosis of depression is also valid. The diagnosis must have been made within the last 12 months.

Question 11: Medication

It is important to understand that claiming for medication is not related to how it is packed or who delivers/assists with it but the time spent with the resident assisting, observing, explaining the medication and action required.

Factors to consider in determining the time spent includes:

- Number of medications
- Types of medications
- Frequency of medications
- Diagnosis
- Behaviours
- Spiritual or cultural rituals

Do no forget patches, drops etc. If a resident is resistive and the staff member has to discontinue the process and return at a later time all of the time taken contributes to the overall total for the 24 hour period.

Question 12: Complex Health Care

This is a very prescriptive question and excludes many of the complex health care activities undertaken in residential care, especially in the area of pain management. This is an area we will need to monitor as an industry.

This question also includes provision of palliative care services (terminal care). Linking in with local palliative care services can assist in the development of a program

Services must have or develop a sound monitoring system for end of life care. Any claims for end of life must be made straight away as they will not be paid retrospectively.

Documentation

- The ACFI tool is an assessment of needs and does not relate to the delivery of care to meet those needs.
- Validation of claims will also occur on this basis.
- Documentation for quality of care and accreditation needs to capture care delivery through a care plan. Progress notes need to identify exceptions rather than routine care.

Services will need to have or develop a good exceptional reporting system and documentation (rather than current system of keeping details of all interventions). A good system will ensure that the care review of the resident and determination of whether the care plan needs to be altered and/or another ACFI appraisal is required.

Financial

- RCS saved rate has to be kept for 12 months and until the ACFI is $15 more than the RCS.
- Major/significant change for RCS residents to move to ACFI can be done anytime but must result in a $30 or more change.
- Must lodge ACFI with Medicare to trigger the RCS saved rate and ensure funding continues.
- Some RCS Cat 8 may receive funding under the ACFI system but to be eligible the funding must be equal or more than $15.

- ACFI reviews require a clinical monitoring system that alerts the service to the potential for a major/significant shift in care and subsequent funding.
- ACFI changes in relations to the residents needs not set time periods

ACFI Assessments, Bonds & Charges

A person is not eligible to pay an accommodation bond if, at the time of the person's entry to the service, the person was eligible to pay an accommodation charge (see subparagraph 57-2(1)(aa)(i) of the *Aged Care Act 1997* (the Act))

A person is eligible to pay an accommodation charge if, at the time of the person's entry to the service, in addition to meeting other eligibility requirements:

- The person requires a high level of residential care (see subparagraph 57A-2(1)(a)(i) of the Act); and
- The person's approval as a care recipient of residential care is not limited under section 22-2 to a low level of residential care (see subparagraph 57A-2(1)(a)(ii) of the Act).

These legislative provisions will continue to apply after ACFI commences. The decision is based on the evidence available regarding the care recipient's care needs at the time of the person's entry to the service.

The evidence regarding whether a person needs a high level of residential care that is normally available at the time of the person's entry to the service is the assessment of their care needs by an Aged Care Assessment Team for the purposes of Section 22-4 of the Act (the ACAT assessment).

If a resident is admitted with a low ACAT a provider can charge a bond. If subsequently the ACFI assessment (28 days later) indicates the person is high care an ACAT reassessment is required to gain high ACFI but this does not affect the bond.

Respite Care

No ACFI is required for respite residents. Respite will be funded at high and low levels The rates for high and low respite are unchanged as of 20th March but will now be expressed only as dollar amounts rather than be linked to specific levels as they were under the RCS. The Department advises that these levels will be indexed in line with ACFI payments so their value should be preserved. These rates may be found at:

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-finance-subsidies.htm

Validation

Validators do not need to review care plans or progress notes. They only need to see the ACFI appraisal pack. They may request to speak to residents and staff regarding the assessment. If they do elect to speak to residents ensure that a staff member accompanies them and that resident consent is obtained.

During the Transition from RCS to ACFI a resident can't get less than the RCS saved rate even if an ACFI assessment is undertaken. Validation of RCS documentation can occur if there is a 2 category jump in care funding/categories in this period. Good documentation on such cases is imperative.

Hospitals

An ACFI classification expires 6 months after direct admission from hospital. If a resident goes home overnight or goes to a transition care place, they will not be deemed to have been admitted from hospital and will not require the 6 month reassessment of ACFI.