Australian Society for Geriatric Medicine
Position Statement No. 10
Residential Aged Care from the Geriatricians Perspective

1. Australia is at the forefront of international research and practice in virtually every field of health care except residential aged care. We currently fail to collect even basic data about the health status of people in residential care; or about our existing health care practices and their outcomes, in this setting. We turn our backs on international residential care comparative studies.
2. High quality health care for residents is achieved through the effective integration of skilled nursing with medical and allied health care. Effective integration of care and assurance of quality require the collaborative development, implementation, and assured adherence to multidisciplinary practice guidelines, and valid quality outcome indicators.
3. A sectoral framework and mechanism for high standard multidisciplinary guideline and outcome indicator development is needed. Guideline adherence and outcome achievement require the generation of incentives through a quality-directed funding system, and an accreditation system that exhibits the professional expertise to engender the respect of nursing, medical and allied health clinicians.
4. Urgent review of the current accreditation system and the steps needed to establish a contemporary model of health service quality governance for the sector is required. In the interim an appropriately skilled and experienced advisory body, which includes medical expertise, should be established to begin to re-channel current inadequate accreditation policies and procedures.
5. The current Residents Classification Scale (RCS) funding instrument is the antithesis of a funding system that generates incentives for quality health outcomes. Urgent action is needed to replace this system with one that links funding with quality care processes and outcomes. In the interim funding should be based on "raw" RCS scores, rather than existing categories, in order to ameliorate the large-scale subversion of clinical activity engendered by the current system.
6. There is a very major loss of potential health care productivity throughout the sector resulting from the inherent inappropriateness and duplication of RCS-related, and accreditation-related, assessment and care input planning processes. Ending the duplicate wastefulness of the current funding and accreditation systems will free extensive clinical and administrative resources throughout the sector. These resources should be redeployed to establish and progressively refine a new integrated funding and governance system that assures quality guideline and outcome-based health care; and provides the necessary professional skill-mix and educational programs.
7. Strategic alliances need to be formed between providers; professional and academic nursing, medical and allied health associations and faculties; and consumers, to establish what is currently accepted best practice within residential care and where investment should be made in targeted research. Both "Centers of Excellence", and a more inclusive and decentralised network of multidisciplinary "Clinical Practice Units" should be established to facilitate these alliances and their aims. These alliances should also serve as a vehicle to facilitate Australian participation in international comparative studies of quality residential care.
8. Research is needed to examine the reasons for the poor retention and attraction of nurses in the sector. One disincentive worthy of study is the absence of effective guidelines and lack of sufficient expert support for the management of behavioural and psychological symptoms of dementia. Another is the lack of clinical benefit for residents, and employment satisfaction for nurses, deriving from the duplicated funding and accreditation system information and documentation burdens.
9. The care of future populations of residents will require a sustainable infrastructure of adequate numbers and quality of residential care places in the face of unprecedented demographic changes. This demands ongoing review of (especially not-for-profit) providers' capacity to accumulate capital; the re-examination of existing age-based regional bed provision formulas; and early consideration of the need for a "pre-funded" contribution system to secure future long-term care financing.

This Position Statement represents the views of the Australian Society for Geriatric Medicine. This Statement was approved by the Federal Council of the ASGM on 8 October 2001.

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BACKGROUND PAPER

Introduction

The demography of the Australian population is changing dramatically. Sixty-eight percent of people currently in nursing homes are over the age of 80 [1], and the number of people over 80 is projected to increase by more than 200% by 2030 [2], compared to an overall population increase of 30%. The likelihood of being admitted to a nursing home doubles with each 5-year increase in age, reaching 35% in people over 85. [3]. There are already about 74,000 high level care places (former nursing home), and about 67,000 low level care places (former hostel) [4], located within about 3000 Commonwealth funded residential aged care facilities. Over the last 15 years growth in nursing home bed numbers has been stifled, and home-based aged care options have been expanded [4]. However population ageing [5], and particularly the increasing prevalence of the neurodegenerative syndromes that accompany aging [6], will result in the need for major growth in residential care provision.

Current Australian residential aged care funding

The current Commonwealth contribution to residential aged care funding is based on the Resident Classification Scale (RCS) [7] which is the result of progressive refinement of a model of the cost of care-related inputs. The RCS asks: "what is being provided"; but not: "what is required to give quality care"; and tends to reward deterioration in resident function when associated with the need for more care [8]. It is the antithesis of a funding system that generates incentives for quality health outcomes. The RCS diverts the energy of scarce qualified nurses and allied health practitioners into "gaming the system"; and creates a vast, but clinically largely irrelevant, documentation burden in support of the category claims. Funding is further diverted out of care hours to RCS financial managers, and out of the sector to RCS software products, and "RCS Consultants": who siphon off a percentage of the increased subsidies that they guarantee providers. The Department of Health and Aged Care monitors the mathematically implausible raw dependency score distributions of facilities' RCS claims, and currently expects to claw back $71 million by addressing "inappropriate" classifications [9]; through committing further resources to review visits, which downgrade about 40% of claims back through a lower category border [10]. The circuit (or circus) is completed by providers activating appeal provisions against category downgrades. The sector is awash with meticulously analysed RCS category data, which are the only available data about any care-related characteristic of the residential population. These data tell us nothing about residents' health care needs or the quality of care being provided.

Reviewing the current system of nursing home subsidies, the Australian Productivity Commission reported that: "quality care is central to the well-being of nursing home residents, and the standard of care supported should be a conscious and transparent decision"; and described the current system of subsidies as: 'inappropriate and inequitable'. The Productivity Commission went on to recommend the establishment of a national benchmark of quality residential care, with funding related the achievement of the benchmark [11].

Current Australian residential aged care accreditation

Balsamo has stated: "at the most basic level, a decision-maker may wish to have a monitoring system, any system, in place as a watchdog to coax providers into desired behaviour. Precision and accuracy may be secondary concerns …and… in their eagerness to obtain useful information about provider performance purchasers and consumers naively may except flawed evaluation, and thereby create perverse incentives for providers that undermine the very qualities they wish to foster." [12].

Ensuring the availability of essential clinical skills is a proper concern of residential health care governance. Access to a broad range of integrated high quality health services is necessary for the physical and mental health of residents. Current legislation (*Quality of Care Principles 1997* [13])

nominates the provision of arrangements for "aural, community health, dental, medical, psychiatric and other health practitioners to visit residents"; and "access to specialised therapy services" including "speech therapy, podiatry, occupational or physiotherapy practitioners".

However the legislative intentions appear to have been interpreted idiosyncratically by the authors of the current accreditation standards. The "Standards and Guidelines for Residential Aged Care Services" [14], despite having a number of category headings under which availability of certain health service would be appropriately specified, actually fail to nominate almost all of the services nominated in legislation as needing to be available in order to meet any health care standard. Health Care Standard 2.6 is headed: "Other Health and Related Services"; and its "Expected Outcomes" are: "Residents are referred to appropriate health specialists in accordance with the resident's needs and preferences."; and the "Criteria" then nominate "complementary therapies" and "complimentary treatments" as the single service needing to be specifically shown to be available in order to meet this standard. Complimentary therapies and treatments are not nominated in legislation but need to be available to meet accreditation requirements. Many specialist allied health and medical services are nominated in legislation but do not need to be shown to be available to meet accreditation requirements.

Standard 2.6 can serve as an example of the general shortcomings of the health care standards to the extent that: complementary therapies are not defined; the health needs which are to met by these therapies are not specified; no evidence-based practice guidelines in relation to the efficacy or risks of complementary therapy are offered, referred to, or promoted; and the desirable outcomes to be achieved from these interventions, and their measurement, are not specified

The current Standards are totally silent on common important health issues such as the recognition and treatment of depressive disorders; and the prevention of hip fractures.

Current accreditation requirements demand that providers take on a second major information, assessment, care process determination, and documentation burden, in addition to the RCS, but again there is no dividend in the form of collection and dissemination of useable health care data,

The US Institute of Medicine has defined quality health care as: "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" [15]. Objective evaluation of the achievement of "desired health outcomes" requires the development and application of valid clinical outcome indicators [16]. Evaluation of the achievement of "consistency with current professional knowledge" implies a process measure and has come to signify adherence to evidence based practice guidelines. Once these fundamentals are in place valid data about outcomes and guideline adherence can be pooled and interrogated for the purpose of comparison of facilities and for progressive service development. Transparency is ensured through consumer, provider, funder and researcher access to these data [15].

The current accreditation agency has thus far failed to submit its standards to external validation, either through cross-reference to the Australian Council for Health Care Standards, or to external assessment by any recognised international standards evaluation body. Gray has recently recommended that the accreditation agency consider the introduction of objective measures of continuous improvement; and that an Industry Advisory Committee be formed to assist the Agency [4].

We are not always obliged to look offshore for high calibre quality assurance models that could be emulated in residential care. The Australian national sub-acute and non-acute patient classification system is linked with outcomes-orientated medical standards [17]; and the National Prescribing Service (NPS) [18], which targets the quality use of medications, provides a shining example of health sector quality governance.

In addition to providing a high quality journal, and educational services ranging from on-line satellite workshops to practice visits, the NPS

interrogates a database of Pharmaceutical Benefits Scheme prescriptions for atypical prescribing patterns of individual practitioners. These practitioners are then provided with information about their prescribing pattern, compared to the normative patterns of their peers; as well as with a well researched succinct evidence-based guideline, which is pertinent to the clinical context of their questionable prescribing practice. The NPS is a company limited by guarantee, incorporated under corporations law, with prescribed membership representing all relevant sector interests and expertise, and elected according to an Electoral College system. General practitioner body representatives have the greatest numbers (three), but no professional or industry group commands a majority on the board. The NPS is independent of Government and its quality activities are separated from compliance and sanctions. A governance system of equivalent calibre with equivalent resources would transform the quality of multidisciplinary health care delivery to the residential aged care sector.

Relationship of funding and accreditation

The RCS subsidy system and the Health Care Standards of the accreditation system are fundamentally involved with the same variables: assessment and provision of care. The RCS examines these variables under 22 headings that are rated and then totalled for funding category determination [8]. The accreditation system requires that care needs are assessed and provided for under each of the 19 Health Standards [14]. Many of the RCS headings and Health Care Standard headings are similar.

The RCS subsidy system and the accreditation system are managed independently by the bureaucracy and Agency. Separate manuals are issued. Reporting is through separate channels. RCS review and accreditation compliance visits are conducted by dedicated officers of the Department and Agency respectively. The complexities of each system lead providers to develop different senior nurses as RCS specialists or accreditation specialists. Staff training in RCS and accreditation-related procedures are separate processes. Comprehensive separate documentation of assessment and care provision outcomes completes the process for each system: since it is on documentation that rejection or failure, respectively, will be based.

In order to survive providers are obliged to commit major human and financial resources to, and all residents are obliged to undergo, two highly complex independent processes of assessment and consideration of care provision, neither of which, as we have argued above, is likely to result a beneficial health care outcome for these residents. From the point of view of loss of potential productive clinical resident care, the magnitude of these misdirected resources, as a proportion of the $4 billion in Government outlays to the 3000 current facilities, is unknown, but probably runs into the tens if not hundreds of millions of dollars.

In the USA a case mix funding model, based on "Resource Utilization Groups", related to the "Resident Assessment Instrument", has been developed to meet the need for staffing level determination, as well as providing funding incentives for quality assurance [19]; and has been the subject of international comparative trials [20]. Other valid risk-adjusted quality outcome measures have also been developed based on data collected for reimbursement purposes [21].

The "Resident Assessment Instrument"

In 1990 the Resident Assessment Instrument (RAI) was introduced into the long-term care setting in the USA and is now the international benchmark for practice and research in quality health care in this setting. Over the last decade the RAI has been translated into 14 languages [22], and there are ongoing international comparative studies [23].

The RAI attempts to link regulation and funding with quality care processes and outcomes, and incorporates consideration of the medical service [24]. By 1997 a database of 2.7 million individual RAI assessments had been assembled [23]. The pooled database has been interrogated to study correlates of conditions including falls [25], and rates of severe persistent pain [26] in nursing homes. Cross-facility comparisons and the relationship of outcomes with characteristics of facilities can be studied [25]; as can interstate

[26], and cross-national variables [23]. These data are accessible to consumers [27]. The reliability and validity of RAI data items [28], and the strengths and weaknesses of this system [29] are debated in refereed journals.

Reviews, pre and post introduction of the RAI, report statistically significant decreases in the prevalence of psychotropic drug use [30]; the use of restraints, and indwelling urinary catheters [22]; and bowel incontinence in the absence of a toileting program [24]. Increases have been shown in documented advance directives, and behavioral management programs [22].

Kane [16] has recommended that the RAI should evolve further in the direction of subgroup stratification, rather than all residents being assessed and managed under a generic protocol: to facilitate both clinical pathways and Diagnosis Related Groups (DRG) funding. Suitable subgroups may include people with: behavioral symptoms of dementia; chronic (stable) physical disability; palliative care needs (including advanced neurodegenerative disorders); and those with restorative care potential [16].

The RAI was created and refined in a climate of commitment to teaching and research in nursing home health care [31], including medical resident training programs [32]. If the RAI or any high calibre derived or de-novo system of integrated health care delivery is to be achieved in Australia, our participation in evolving RAI-related international best practice comparative studies may be a cost effective and risk-free first step. Such a system cannot flourish without high quality education and research support, and this in turn will require an infrastructure of residential care "Centres of Excellence", preferably linked to an inclusive and decentralised network of multidisciplinary "Clinical Practice Units", involving as many facilities as possible. Progress in this direction cannot begin in the absence of a policy framework supportive of the establishment of the necessary strategic alliances between providers; professional and academic nursing, medical and allied health associations and educational institutions; and consumers.

Long-term considerations

The health care of future populations of residents will depend on the sustainability of adequate numbers and quality of residential care places in the face of major demographic changes. The adequacy of the current high level care accommodation fee system in allowing (especially not-for-profit) operators to accumulate funds for the major refurbishments required to meet looming 2008 Certification standards [4], and to build much needed new high care facilities, appears dubious [33].

For the last decade and a half planning for regional residential bed provision has been based on ratios to population aged 70 and over [4]. This formula for calculation of provision will, possibly even within 5 to 15 years [5], underestimate need and result in bed shortages. Beyond this time-frame progressively more severe shortages will occur because the numbers of people aged 80 plus, which more truly determine required bed provision, will continue to grow much more rapidly than those aged 70 plus [2].

Early consideration of private and/or public "pre-funded" contributions to future long-term care financing; rather than exclusive reliance on the "pay as you go" system, is also essential, if the risk of a future funding crisis, and socially disruptive inter-generational tension, is to be properly evaluated in time for corrective action to be taken [34]. Voluntary products from the insurance industry could be introduced within a regulated framework, and/or consideration given to the introduction of a compulsory taxation levy to help finance future long term care; but it needs to be appreciated that there are very long lag times before these initiatives generate meaningful dividends.

Conclusion

The Australian residential care sector has advanced significantly in the last 15 years. Major gains have been made and are being consolidated in many areas including nursing practice, consumer focus, organisational management, resident choice and lifestyle, hotel services and facility architecture.

However from the point of view of health service delivery to residents, geriatricians find the key structural funding and accreditation components of the sector to be antithetical to the provision of integrated evidence-based multidisciplinary care. A high calibre guideline and outcome-focused system of funding and governance, which includes medical care, appears to be capable of being established by correction of a current large-scale misdirection of care-related priorities, resources and activities. We believe this matter merits the urgent attention of policy makers.

There is also a pressing need to take action to ensure adequate provision for future residential care requirements, related to the rapid ageing of our society.

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