New Zealand
Aged Care Association

Submission to DHB Shared Services

on the

2016/2017 ARRC and ARHSS Contracts

16 November 2015

Introduction

1. This submission is from the New Zealand Aged Care Association (NZACA), the peak body for the aged residential care sector in New Zealand. With over 570 members, we represent 90% or approximately 33,000 beds of the country's aged residential care (ARC) sector. Our members range from the very small stand-alone care homes to the large co-located sites that include care services and retirement villages. Our members' services include rest home, hospital, dementia and psychogeriatric care, as well as short-term respite care.

2. Advocating and lobbying to government to shape policies and create an environment that helps our members provide outstanding quality care is at the heart of what we do. We also provide leadership on issues that impact on the success of our members, for example, the work we are currently doing on the Equal Pay Case. We also produce valuable research, professional development opportunities, information and publications to help our members make informed business decisions, improve capability and keep them up to date with sector developments.

3. This submission on the 2016/2017 Aged Related Residential Care (ARRC) agreement and the Aged Related Hospital Specialised Services (ARHSS) agreement has been prepared following extensive input from our members. We have convened face-to-face meetings over the past few weeks with members in Auckland, Wellington and Christchurch, as well as receiving email correspondence and phone calls from our wider membership with their views.

4. We have a small team of five staff based in Wellington and led by Chief Executive, Simon Wallace, a representative Board of ten members chaired by Simon O'Dowd and a network of thirteen branches around New Zealand.

5. Any enquiries relating to this paper should in the first instance be referred to Simon Wallace, NZACA Chief Executive at simon@nzaca.org.nz or by phone on 04 473 3159.

Executive Summary

6. This paper highlights the key issues that NZACA would like to see addressed as we enter the upcoming negotiation process with District Health Boards (DHBs) and the Ministry of Health (MOH) on the Aged Related Residential Care (ARRC) agreement and the Aged Residential Hospital Specialised Services (ARHSS) agreement for 2016-17.

7. While this submission deals with issues that are being progressed at an ARRC Steering Group level, including bariatric equipment, palliative and end of life care and complaints and auditing, it is critical that the upcoming negotiations are cognisant of the Equal Pay negotiations that will be occurring parallel to the ARRC negotiations. The Equal Pay settlement (if reached) will have direct consequences for the ARRC agreement.

8. The crisis with interRAI regarding access and availability of training is also discussed in this submission. It will need to be addressed given the contractual requirement placed on NZACA members as a result of the mandatory implementation of interRAI from 1 July 2015.

9. Other issues canvassed in this submission include financial auditing, ambulance, IT efficiencies and the need to fix some problematic clauses in the contract for our members.

Recommendations

For immediate action

10. The 2016/17 ARRC and ARHSS agreements recognise the increasing **palliative and end-of-life care** needs that are now being placed on NZACA members and introduce a distinct palliative care supplement to meet the costs and resources associated with these extra needs.

11. The 2016/17 ARRC and ARHSS agreements confirm the **availability of ongoing training and funding to support the use of interRAI** and ensure that data is being provided to NZACA members on a regular and ongoing basis.

12. The 2016/17 ARRC and ARHSS agreements acknowledge the affordability issues that exist with respect to **ambulance charges**, cap the cost, limit the number of trips a care home must pay for a resident and introduce a rural supplement.

13. The 2016/17 ARRC and ARHSS agreements recognise the extra costs that NZACA members are incurring for **bariatric and other special equipment** as well as the additional staff resource required to deal with higher need residents and fund this accordingly.

14. The 2016/17 ARRC and ARHSS agreements allow NZACA members to charge **premiums on respite** and short stay residents.

Other key priorities

15. The 2016/17 ARRC and ARHSS agreements recognise a settlement (if reached) in the **Equal Pay n**egotiations for care and support workers will require the inclusion of terms of conditions of such a settlement as well as the mechanism by which NZACA members pay such workers.

16. The 2016/17 ARRC and ARHSS agreements recognise that a nationally consistently, cross-agency framework is needed to streamline the **complaints and auditing** process.

17. The 2016/17 ARRC and ARHSS agreements remove (or do not include) any requirement on **financial auditing with respect to additional charging**.

18. The 2016/17 ARRC and ARHSS agreements provide incentives to NZACA members and DHBs to **support IT efficiencies** such as the use of Medi-Map, Toniq and others.

19. The 2016/17 ARRC and ARHSS agreements amend the clauses relating to the **repayment of residents and overpayments** from 10 to 20 working days.

Comment

Palliative and End of Life Care

20. Palliative and end of life care is fast emerging as a major issue for our members. NZACA welcomes the range of work that has been announced or initiated this year either by the MOH or individual DHBs. This work includes the funding announced to hospice that also involves our members, the adult palliative care review and the inclusion of palliative care as a major strand in the refresh of the Health of Older People Strategy (HOPS).

21. Evidence is showing that:

- Deaths in aged residential care have increased faster than for any other place of death in New Zealand.
- Aged residential care has also been an increasingly important setting for deaths from cancer, exceeding deaths in hospitals in 2010.
- Aged residential care is also the most common place of death for New Zealand women, regardless of age or cause of death.
- Over a 20 year period, research is showing that people are entering aged residential care more frail than before.
- The combination of short stays, higher needs and more end of life care means that more resources are required to care for residents and their families.

22. Effectively, the case mix has changed and is expected to continue to change in the future, with increased frailty on admission, shorter stays and an increased number of deaths at the oldest ages. The current structure of payments means that the MOH and DHBs have effectively passed mortality risk and the risk of increased frailty on to NZACA members.

23. Reform of payment systems in the UK, the USA and Australia all show that a higher payment is required for palliative and end of life care. There are benefits to the system of providing high quality palliative care, most notably reduced costs for hospitals.

24. Payment levels to aged residential care facilities were set with an implicit case-mix at the time. Payments to aged residential care facilities need to be re-weighted to reflect the increased number of deaths and increased frailty that apply now. Reimbursement schedules need to explicitly allow for end of life payments; or a mechanism needs to be set in place to regularly re-weight payments according to increased frailty and increased number of deaths.

25. The interRAI suite of assessments needs to include the palliative care assessment tool for consistent assessment across New Zealand, beyond the pilot programme that is currently being trialled. At the same time, the reimbursement of palliative and end of life care needs to be consistent across all settings of end of life care and across all DHBs.

26. To evidence and support NZACA's case for a distinct palliative care supplement that recognises the changing needs described above, we commissioned Heather McLeod and

Associates Limited to provide an analysis of the current situation with regard to palliative care in New Zealand. As noted above, her work also reviews the situation in overseas jurisdictions including funding models in the UK, USA and Australia. This report is attached.

interRAI training and data provision

27. Discussions are currently taking place with DHB officials on the lack of training courses that are currently available to our members. This has now reached a point of crisis where no training places are available anywhere for the balance of the 2015 calendar year. Priority places will only be assigned in the first quarter of 2016 and no training commitments can be made by central TAS (Technical Advisory Services) beyond that. Clause D15A.5 of the ARRC contract sates that the appropriate DHB will 'provide ongoing training to support the effective use of interRAI'.

28. The NZACA accepts that a solution is being worked on to prioritise training needs for the short term including the recruitment of DHB lead practitioners to help with this task. Given the demand for training, NZACA would like to see options put forward for the private sector (aged residential care providers themselves) to be able to offer interRAI training and so remove the monopoly that central TAS currently has in running the training programme.

29. With respect to data, the ARRC contract also makes clear the DHBs' requirements. Clause D15C is explicit in stating that reports about resident data at an individual and aggregate level should be provided. While we understand this is happening to some extent with members, our understanding is there is no regularity or uniformity relating to the provision of data.

30. From an NZACA perspective, we would certainly be keen to access the interRAI information at an aggregate level, yet it is still not available. Data and insight of this nature is critical to shape future policy settings so it is essential that progress is made to make this information available.

Ambulance

31. The already high cost of ambulance charges was compounded in January 2014 when St John Ambulance increased their charges for non-emergency transfers by 38% nationally. While this increase has been felt by all NZACA members, our rural members have been particularly hard hit. Examples of such costs include: $1,000 each way between Taumaranui and Hamilton; $800 each way between Waihi and Hamilton; and $500 each way between Ashburton and Christchurch. Charges in the Wellington region (Wellington Free Ambulance) are also high, with a charge of $150 each way between Kapiti and Wellington.

32. The ARRC agreement (D20.1 a. to h.) means our members must meet the costs of transport for residents requiring transport to the nominated services. Because of the distance, and also due to the frailty of residents, an ambulance is often the only appropriate means of transport, especially where hospital shuttles are not available.

33. The NZACA has been working constructively with St John Ambulance over the past few months to better understand the usage patterns of our members. From this work we have produced a rest home utilisation report to provide trend and demand information that may help reshape and reduce ambulance demand. Of the approximately 400,000 emergency calls a year that St John Ambulance receives, around 30,000 are associated to an NZACA member. This is 7.5% of total call outs (note: this work was done prior to Bupa joining the NZACA in September, so with its 4,200 beds, the figure is likely to be higher).

34. There is further work to be done between the NZACA and St John Ambulance to refine the utilisation report, including separating out emergency and non-emergency calls as well as identifying rural facilities to understand their usage patterns. This may get us to a point where we could look at clustering rural NZACA members so that one ambulance trip could transfer two residents. Nevertheless, ambulance costs will still remain high. NZACA believes the ARRC contract for 2016/17 should acknowledge affordability issues especially for rural members, and either cap the cost or limit the number of trips a care home must pay for each resident.

Bariatric and other special equipment

35. With the well reported increases in obesity amongst the New Zealand population (and worldwide), NZACA members are now starting to see more obese residents come into their care homes, including residents that are morbidly obese. To support these residents, our members need to have the right equipment to safely handle these needs. Such equipment includes oversize beds and hoists and other specialised bariatric equipment.

36. The issue is multi-faceted because:

- There is an extra cost for oversized beds and hoists, e.g. members have told the NZACA that the cost of a hoist can range in price from $4000 to $11,000.
- Obese residents typically require additional staff to provide care in a safe manner, e.g. often it can take three staff to handle a morbidly obese resident.
- Obese residents will often take longer to provide care given the extra precautions that need to be taken.
- In some cases, rooms, doorways, corridors and the built environment as a whole needs alteration to handle obese residents and equipment.

37. All of the above factors add up to significant extra costs and capability for our member care homes, not covered in the current ARRC contract (refer section D15.3). While it is acknowledged that some DHBs will look at bariatric provision on a case by case basis and that a review of the Ministry of Health's (MOH) assessment and provision of bariatric equipment is to take place in 2016/17, there is still a lack of national consistency for the sector.

38. Various schemes, such as the lending or sharing of equipment, or equipment libraries, have been trialled in the past. NZACA members have said that such schemes, while well

intentioned, have mostly been unsuccessful.

39. There has been discussion both now and in the past about setting a threshold on the weight rating of a standard bed or hoist. A resident above this threshold could qualify for extra funding with bands of funding applied at various stages of the obesity spectrum.

40. Apart from bariatric equipment, NZACA members are also reporting greater demand on other specialised equipment. These include, but are not limited to, gutter frames, pressure reflect mattresses, sensor mats, wheelchairs and wound dressings, required to service the increasing levels of resident acuity in their care homes.

41. Finally, there needs to be a clear description of what is defined by customised equipment. Such equipment is currently excluded from clause D14 of the contract, yet NZACA members are unclear as to what is 'in' and 'out' on this list.

Premiums on Respite Care

42. There is some ambiguity in the contract as to whether our members can charge premiums to short stay/respite care residents. Some NZACA members, because they have tailored respite contracts with their individual DHB, do have clarity on this issue and can charge premiums, but for others it is less clear. Given the higher costs (admission/discharge, more medication, often larger rooms, more servicing and staff costs) to accommodate short stay/respite residents, NZACA members need the ability to premium charge. With the ARRC Steering Group currently working to achieve national consistency on respite contracts, it is opportune that this review allows for all our members to be able to charge premiums on respite care.

Equal Pay Negotiations

43. The A21 negotiation process for the 2016/17 year will need to be cognisant of the Equal Pay negotiations that are currently underway to settle caregiver and support worker wages in the aged residential care sector. Any agreement that is reached in these negotiations will need to include terms and conditions and a mechanism by which NZACA members pay such staff. There may also be a need for a separate appropriation that hypothecates funding for caregiver and support worker wages.

44. The ARRC contract in 2016/17 will have to provide clear guidance for NZACA members on what a settlement for care and support workers means for the relativities of those workers not included in the scope of an agreement. For example, such workers include those involved in food preparation, maintenance and gardening, and also enrolled nurses (ENs) and registered nurses (RNs). As the majority of care and support workers are not part of a collective agreement, NZACA members will also need advice as to what the practicality of any settlement means for workers who are on individual employment contracts (IECs).

45. If the final settlement from the Equal Pay negotiations requires NZACA members to provide services that exceed their agreed contractual responsibilities under the ARRC agreement, then we would need to invoke the A23 variation to agreement clause, especially in cases of a

funding shortfall.

46. An initial recommendation from the care and support worker negotiation meeting of 9 November has suggested that in the event of a settlement:

> "It will be essential to ensure that an ongoing reporting mechanism is in place to track the implementation of the settlement and ensure the planned outcomes are achieved. It is likely that this would need to be managed centrally from the Ministry of Health, however, consideration of the format and type of information collected will need to be developed in consultation with the sector to ensure it can be completed by all providers."

The NZACA is concerned that if this recommendation is adopted it will create another compliance burden for members who are already weighed down with unwieldy regulation

Complaints and auditing

47. This is an area of concern for NZACA members that has also been identified by the ARRC Steering Group as a focus area. Our members are required under the Health and Disability Safety Act to send to HealthCERT a Section 31 Notice if:

- Any incident puts at risk a resident
- Any investigation by the police takes place as a result of an incident
- Any death of a resident that is required to be reported under the Coroners Act.

48. Often other agencies will also become involved, including the Health and Disability Commissioner (HDC), the local DHB and WorkSafe New Zealand. Having to engage with a number of different agencies, each with their own requirements places an enormous onus on care home managers and takes precious time and attention away from the day to day running of a care home.

49. Our members have said there needs to be a joined-up approach to the complaint process so that they don't have to supply information to a range of different government agencies. Only recently, NZACA visited a member care home and witnessed first-hand the sheer amount of documentation (as well as time taken) required to meet the demands of the DHB, WorkSafe and the HDC with respect to a complaint.

50. The ARRC contract is silent as to the legal obligation and rights of the care home in circumstances where a complaint is made – the balance is tipped in favour of the investigating government agencies. Some NZACA members have reported that where Health Cert or the relevant agency has identified corrective actions that have been satisfactorily completed, these can still detrimentally impact future audits and certification long after such incidents have been corrected or resolved.

51. A nationally consistent framework is needed that streamlines the complaints process, reduces the workload for our members (and equally that of government agencies) and gives the care home some say in the complaint process.

Financial Audits

52. The NZACA has been asked to respond to a short paper by the MOH (31 July 2015) on financial auditing with respect to additional charging. For the record, our members have always been able to charge extra for other additional services (such as the excluded services set out in clause D14).

53. As suggested in the paper, the Association would be concerned if auditors were to ask care homes for documentary evidence to prove they have followed the process around how they offer choice, whether they promote it, and how they have managed the exception process, e.g. no standard rooms, more than 90% occupancy and 10km radius. Not all NZACA members keep these records and on balance it is probably unreasonable to expect them to do so when time is better spent focusing on the care and welfare of their residents.

54. As well as the paper implying that premiums are at the discretion of the resident, the MOH paper also suggests that a DHB Health of Older People (HOP) Portfolio Manager has some say in what constitutes a premium room – this is not right. A premium room is not necessarily related to having an ensuite, having a view, being north facing or being larger – it could relate to the design, fit-out and other amenities of the building.

55. This guidance, while well intentioned, is in the NZACA's view unnecessary. It will create more problems than it solves and would be best avoided. There is already a useful flowchart and other guidance on the DHB Shared Services website that provides clear guidance to care homes on premium charging rules.

Support for IT efficiencies

56. There is concern from NZACA members at the slow and cumbersome nature of Healthpac processing. Our members have embraced interRAI, which has required not only clinical, but also technology upskilling. Yet at the same time, the MOH and DHBs expect our members to communicate with Healthpac through a manual paper based system. NZACA has raised this issue with officials on several occasions in the past and has been told that an electronic payment system is not a priority. NZACA would like a commitment and timeframe as to when Healthpac will move to modern electronic processing.

57. As noted in our 2014 submission, the adoption of Medi-Map, Toniq (electronic medications charting systems) and other IT providers, has significant benefits for the wider health system by reducing medication errors, reducing wastage and integrating patient management systems. Over the past year there has been increasing usage of Medi-Map and Toniq and further to discussions at the ARC Steering Group, there is now an opportunity to incentivise not only our members, but also DHBs and pharmacists to adopt these and possibly other IT providers in order to streamline medication management.

Other clauses requiring amendment

58. The requirement to repay residents (their families or estate) within 10 working days of either a resident's death, discharge or transfer elsewhere is simply too short. This period provides insufficient time for care homes to recover incidental costs owing on that resident's account. NZACA suggests that a more reasonable period would be 20 working days for the repayment.

59. In a similar vein, we suggest that clause A9 requiring our members to pay back overpayments also be extended from 10 to 20 working days, on the basis that some care homes may not be aware of an overpayment inside the 10 day timeframe and for others it may take more time than that to have such payments approved.

60. In 2015, finalised ARRC and ARHSS contracts were sent to our members at a very late stage, leaving them little time (less than two weeks) to peruse, sign and return to their respective DHBs. While this might seem reasonable, the reality is that facility managers and owners can be on leave or absent for a number of reasons and NZACA members have their own protocols about signing and approving the contract which often takes time.

Inflation adjustment

61. Notwithstanding the other points made in this submission, our members need a realistic annual inflation adjustment each and every year. The Consumer Price Index (CPI), while an indication of general household inflation, is not an accurate reflection of the inflationary pressures on the aged residential care sector. The best measure of inflation for our members is the Aged Care Price Index compiled by Statistics New Zealand (SNZ) and we believe this index should be considered as part of the annual inflation adjustment process.

ARRC Steering Group is reference point

62. From time to time other issues come up outside of the ARRC and ARHSS negotiation process that in our view should be first referred to the ARRC Steering Group for discussion and decision. These may be matters related to policy and/or operations. A recent example of this is the current consultation taking place with respect to the design of secure dementia units. While our members have been encouraged to attend these sessions, they do so without context and not necessarily understanding why such work has been initiated. In this instance, matters relating to the design of secure dementia units could have major implications for our members meaning the ARC Steering Group must be the first port of call on such matters.

Simon Wallace
Chief Executive
NZ Aged Care Association

End.