Submission to DHB Shared Services

on the

2017/2018 ARRC and ARHSS Contracts

28 October 2016

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 590 members, we represent over 90% or approximately 35,000 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 and a small number of YPD beds.

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. 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 2017/2018 Aged Related Residential Care (ARRC) agreement and the Aged Related Hospital Specialised Services (ARHSS) agreement has been prepared following input from our members. 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 2017/2018.

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

5. Any enquiries relating to this paper should in the first instance be referred to Kathryn Maloney, Senior Policy and Research Analyst at kathryn@nzaca.org.nz or by phone on 04 473 3159.

Comment

Funding model review

6. This year's negotiations on the ARRC agreement are likely to be running simultaneously with the Funding Model Review and depending on timing may or may not influence the outcome of the 2017/2018 negotiation. The NZACA, like other providers, has already provided a submission to the team at DHB Shared Services with our view on the scope of this review. For reference, this submission is attached.

Equal pay negotiations

7. At time of writing the Equal Pay negotiations are still continuing although there may be a resolution in the next few months. 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. The ARRC agreement in 2017/2018 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 and registered nurses.

8. 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 may need to consider invoking the A23 variation to agreement clause, especially in cases of a funding shortfall.

Palliative and end-of-life care

9. Palliative and end-of-life care continues to be an issue at the top of our members' minds. There is clear evidence to show that more people will be dying each year, and people will be dying at older ages with increased presence of frailty and comorbidities including dementia. The updated projections[1] estimate the following.

    - In the next 20 years the number of deaths in New Zealand is projected to increase by almost 50 percent, from the current rate of around 30,000 per annum to 45,000 per annum in 2038.
    - By 2068 the number of deaths per annum is projected to reach 55,500. This will be a result of people living longer than before, coupled with an absolute increase in numbers due to the 'baby boom' generation (born between 1946 and 1965) entering their older years.
    - There will be a rapid increase in the age at death. In 20 years over half of deaths will be in the age group 85 years and over. Deaths at the oldest ages will be predominantly women.
    - There is not likely to be a substantial increase in the proportion of Māori deaths or Pacific deaths, but the proportion of Asian deaths is likely to increase from 3.3 percent in 2016 to 8.2 percent (of the total number of deaths) by 2038.
    - The rising prevalence of comorbidities suggests that people's trajectories of illness at the end of life could be very hard to predict, plan and coordinate for.
    - The number of deaths in which palliative care is required is projected to increase from 24,680 in 2016 to over 37,286 by 2038. This is an increase of 51 percent. This shows that the proportion of deaths needing palliative care will increase from 80.9 percent in 2016 to 82.8 percent in 2038. These figures of projected need for palliative care do not distinguish between the need for specialist palliative care and primary palliative care.
    - Based on historic patterns of place of death, the need for palliative care is projected to increase between 2016 and 2038 by 37.5 percent in public hospitals, 84.2 percent in aged residential care and 51.8 percent under hospice care (including those under hospice services in aged residential care and in the community).

[1] Projections of the future need for palliative care services were commissioned from Prof. Heather McCleod in 2016 and are summarised here.

10. The Adult Palliative Care Review shows the need for national standards which we agree with. However, such standards cannot be imposed on the sector without the commensurate increase in support and funding.

11. We believe there is currently an inequity of funding between hospice and ARC given the number of New Zealanders dying in our care homes, including the funding provided to pre- and post-bereavement assessment. Hospices provide excellent care, but a single national funding model and contract is required regardless of where the person is receiving care.

12. The members of NZACA identified a number of ways ARC could add to the quality of the end of life for older citizens living in aged care. Suggestions included:

    - further education of staff in caring for residents in the 'fourth age';
    - additional subsidised GP and other specialist visits, so the resident has high level input into their needs. This could include an on-call Palliative Nurse to assist where the need arises;
    - increased staffing at 'end of life' so the resident has a staff member with them when no relative is available as well as the availability of skilled staff to support the families/whānau;
    - the availability of accommodation that is suitable for the families/whānau such as a lounge/bedroom and facilities;
    - further education of the public in relation to Advanced Care Planning and the options available.

interRAI

13. A number of issues with respect to interRAI training and data development that were included in our submission last year have been addressed, but members have still expressed concern again this year at the cost of backfilling staff when RNs are on training as well as disbursement costs to send RNs to training in other centres. This is particularly an issue for smaller members and those in locations away from training centres where courses are taking place.

14. Currently, there is inconsistency across the DHBs regarding assessments and their individual approaches to potential changes in levels of care. The time it takes to review an application for change in level of care varies from 1 day through to several months in some exceptional cases. Average times across each DHB vary from 1 day through to 17 days. It is essential that all ARC residents receive the same levels of care and the same access to changing levels of care regardless of where in New Zealand they live.

15. As we move into this year's negotiations, the NZACA believes that it is timely to review the nineteen issues that were raised by the NZACA in the letter to Minister Goodhew on 1 November 2012. It is time to conduct a stocktake on how those nineteen issues are progressing and identify any areas for review or improvement. See appendix 1 for the nineteen issues.

Special equipment

16. This issue was raised last year and despite some progress has not been addressed adequately. It focuses on the need to recognise the extra costs being incurred by NZACA members with respect to either the purchase or lease of special equipment to meet the needs of bariatric residents in particular. Whilst the NZACA has begun conversations with Enable around the ability to lease equipment, this still does not solve the costs relating to residents needing this care.

17. The recent paper to the ARC Steering Group (6 September 2016) states that the responsibility for provision of equipment to meet the needs of residents assessed as requiring aged residential care is set out under clauses D2.2 (Cost Obligations) and D15.3 (Facilities and Equipment), in the ARRC Agreement. As this paper says, it is the high cost of this obligation that is the major sticking point given the increasing demand from this client group.

18. Earlier this year, through the ARC Steering Group, the DHBs asked the NZACA for more information from their members about the specific issues with regard to bariatric and special equipment. We worked with the DHBs on a tailored questionnaire and below are the headline results:

    - excluding outliers, on average a care home had five bariatric residents in the past twelve months;
    - 32% of care homes had bariatric equipment already available, 50% purchased the necessary equipment and 18% leased;
    - equipment prices ranged from a shower chair at $100 to hoists up to $10,000 and beds up to $11,000;
    - there was significant variation in costs across items, e.g., bed costs ranged from $2,500 to $11,000;
    - 45% said they required extra staffing;
    - the average additional staffing hours per bariatric resident per week was 39 hours;
    - 28% of facilities had refused admission to someone requiring bariatric care in the past 12 months.

Ambulance charges and other transport costs

19. The ongoing issue of ambulance charges is a perennial theme for our members and has been compounded this year with a further increase in emergency charges from St John's. In July 2016, the MOH gave St John's the green light to increase medical emergency ambulance call-out charges from $88 to $98 without any consultation with the sector. From work we have done this year, we know that there are around 30,000 medical emergency ambulance call-outs annually from within the ARC sector, which means the $10 increase equates to a total additional bill of $300,000 annually for the sector as a whole.

20. The increase this year to emergency charges comes on top of a 40% increase in ambulance call out charges at the beginning of 2014. While the increase in charges applies to all our members, it is felt acutely in rural areas where sometimes the cost of non-emergency ambulance charges can be as much as $1,000 one way, depending on location.

21. 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.

22. The NZACA with the support of the DHB Shared Services Health of Older People team has had constructive discussions with St John's about ambulance charges, but the progress is slow on their part. Those discussions have also canvassed the current policy that prevents residents in care from belonging to the St John's Supporters (members) Scheme when those people living in their own homes or in a retirement village can belong to the scheme and therefore qualify for subsidised transport by ambulance.

23. There is increasing admission to hospital-level care which is resulting in an increased need to provide transport to specialist appointments. For example, a resident that requires dialysis is likely to travel to and from the dialysis centre at least three times per week (potentially more as their conditions worsens). This is particularly expensive for members whose facilities are in rural areas.

24. Residents typically need to be escorted to specialist appointments by a registered nurse (RN) who can support and advocate on behalf of the resident. This reduces the number of RNs available within the care home or means that another RN must also be rostered on duty as well, to cover the work of the RN who is accompanying the resident.

YPD contracts

25. Following some major issues between our members and the MOH in 2016 regarding the issuing of YPD contracts, NZACA would like to see the timing of these contracts aligned with ARRC contracts, i.e. 1 July each year so that YPD contracts are circulated to members at the same time the ARRC and ARHS contracts.

Technology

26. There has been little or no progress in this area and while our members continue to embrace interRAI which has been a major culture change for the sector, we continue to have to deal with archaic paper based systems, for example, those used by HealthPAC.

27. We know that the health sector as a whole is rapidly moving to ever more online systems. It cannot be denied that online systems regularly save costs to DHBs and MOH, as routine procedures become streamlined, for example, electronic dispensing will provide cost savings to Pharmac. Many of our members have a desire to take on more technology, however, this can come at a cost, particularly regarding investment in computers and software. We believe that by incentivising our members to continue to make these investments, there will be more efficiencies across the sector, both in terms of time and money.

28. New electronic systems within the New Zealand healthcare structure need to be developed to include ARC providers. Currently, electronic links are frequently established between secondary providers and the medical centres, but these do not include ARC facilities. As an example, Advanced Care Plans for residents and general public need to be accessed by all health professionals who are engaged in that individual's care and the access must be timely. It is essential that these can be accessed by the correct people as and when needed. If there is any move to develop a system to access these electronically, ARC providers need to be involved in the conversation.

Timeframes

29. The NZACA would like to see reasonable timeframes set at the beginning of negotiations to safeguard against issues dragging on for many months and, in some cases, years, when a speedy agreement can be reached. The NZACA is suggesting that all issues raised in this round of negotiations be resolved satisfactorily within twelve months.

Compliance creep

30. Following the enactment of relatively new legislation like the Health and Safety at Work Act (2016) and the Food Act (2014), members are noticing a significant increase in compliance costs. For example, developing the Food Plan and getting it verified is very time consuming while another example includes the laborious processes we need to undertake when employing overseas staff. These requirements are compounding some already onerous obligations that we call compliance creep.

Complaints and auditing process

31. This is carried over from last year and has not been sufficiently dealt with, so our comments from last year remain unchanged.

32. Our members are required under the Health and Disability Safety Act to send to HealthCERT a Section 31 Notice if:

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

33. 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.

34. 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.

35. 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 HealthCERT 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.

36. 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.

Aged care price index

37. Notwithstanding the above points, NZACA members need a realistic annual inflation adjustment each and every year across all bed types. The Consumer Price Index is not an accurate reflection of the inflationary pressures on the ARC sector. The best measure of inflation for our sector is the Aged Care Price Index compiled by Statistics New Zealand. The ACPI established using the QES as a basis is seen as the most relevant to the sector as the staff categories in this index. The latest index (to June 2016) is below:

Producers price index *Base: December 2010 quarter*			
		Aged care QES basis	
		Index number	Annual percentage change
Quarterly			
2014	Jun	1135	1.0
	Sep	1137	0.1
	Dec	1137	0.4
2015	Mar	1132	-0.3
	Jun	1142	0.6
	Sep	1153	1.4
	Dec	1153	1.4
2016	Mar	1164	2.8
	Jun	1175	2.9

Sum up

38. There may well be other issues not canvassed here that may arise in the meantime and we reserve the right to bring these to the table at the ARC Steering Group.

End.

Appendix 1

Nineteen issues that were raised by the NZACA in the letter to Minister Goodhew on 1 November 2012

Use of Assessments

1. A formal agreement by all DHBs to accept that the LTCF interRAI re-assessments to be accepted by NASC/DHB as the basis for funding and care level change.
2. A formal agreement by all DHBs to accept that the LTCF interRAI assessment performed at the aged care facility on a NASC referral for admission, be used as the basis of care level placement.
3. A formal agreement on a DHBs auditing system with the appropriate safeguards and sanctions for each party to ensure the mutually beneficial goal that assessments and reassessments have been performed correctly.
4. Where the audit identifies discrepancies, in the first instance, the National Project to supplement the training for the staff involved.
5. Establish a 'right of review' process with DHBs if the Provider reasonably considers the InterRAI tool has inadequately or inappropriately assessed the outcomes for the resident.
6. Commitment to acceptable homecare assessment and referral timeframes by NASC teams.

Impact on Certification Regime

7. Increased recognition as part of certification for facilities that adopt interRAI as the assessment mechanism (HealthCERT would need to incorporate this into their matrix or award an automatic Continuous Improvement).

Training and Support

8. As a general principle we believe support for aged care providers must be equitable with what DHBs have received.
9. Aged care providers require financial support that covers their RNs training costs including the costs of 'back filling'.
10. Financial support following the rollout for any new or updated interRAI instrument and technical platform version.
11. The project currently only provides access to InterRAI competent RN's. However these RN's may need to collect information from their multidisciplinary teams in order to complete an assessment. As such everyone needs to understand the InterRAI tool. This means consideration must be given, for example, to training sessions for activity coordinators, physiotherapists and dietician.
12. The National project to develop and provide an adoption methodology and/or change management support for organisations to follow.
13. National project to provide a cost modelling for the use of interRAI beyond the role out phase, i.e., who will cover what cost after 2014.
14. Success story: National project to identify and provide an organisation as the success story/case study including supporting data.

Use of InterRAI In the Placement of Individuals

15. A formalised process and agreed national thresholds for referral to long term care.
16. Make it mandatory for all referrals to LTCF to have had an interRAI homecare assessment completed (with the exception being short term care options).

Platform Requirements

17. Assurance on the performance and availability of the national interRAI platform (hosting system) with service level agreement (SLA) to be understood and agreed with provider representatives.
18. For the national platform to support multiple platform/browsers.
19. Agreement that one year before the 2014 deadline all completed assessment information and relevant demographic information will be available for retrieval from the national interRAI platform by all aged care providers who have an electronic patient management system i.e., the information each provider has created for storage on the national system will be available in an appropriate structured form for retrieval directly into their electronic patient management system.