



Aged Residential Care Funding Model Review

Background information to inform your feedback
Following Second Round Stakeholder Forums in November 2018

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Overview

District Health Boards and the Ministry of Health have commissioned Ernst & Young to carry out a Review of the Funding Model in Aged Residential Care

Scope:

- Examine the strengths and weaknesses of the existing Aged Residential Care (ARC) funding model
- Facilitate a transparent process for selecting preferred funding model options, and a transition plan
- Consider the alignment between ARC policy and funding settings and those of other health and social services.

The Review is expected to be completed by Ernst & Young in early 2019. The following information was prepared by Ernst & Young and presented for discussion at Stakeholder Forums in November 2018

Particular areas Ernst & Young have been asked to consider:

- the role of interRAI;
- separation of accommodation and care;
- the efficacy of existing policy settings for primary care, pharmacy and palliative care – as they relate to ARC.

Note the Review's scope is consideration of options for how funding is allocated rather than the quantum of funding received by the sector.

Please refer to [this document](#) for background information for the Round One stakeholder forums.

Forum purpose

- Four forums were held in Dunedin, Wellington, Hamilton and Auckland, with a total of 100 participants. This document is derived from content presented to participants during the forums. It contains background content and specific questions that we are asking you to provide feedback on. This was the second round of stakeholder forums held as part of the funding model review
- The forums had a range of participants from providers, DHB representatives, clinical representatives, and consumer group representatives. We're seeking online feedback from a similar range of people
- The purpose of the forums and the [stakeholder feedback survey](#) is to:
 - Obtain feedback on articulated models of care and desired outcomes, which the funding model needs to support
 - Test potential funding model options focusing on how care is funded
 - Gain insights from you about particular issues the Review is grappling with: rurality, the balance of provider types in the market, restorative care in ARC and premium charging

Recap

Particular elements of the Review's scope

- Articulate the model(s) of care and outcomes that should be incentivised and driven
- Determine how to optimise the use of interRAI within the funding model framework
- Determine whether a standardised approach to funding across aged residential care is feasible
- Consider whether accommodation and service delivery costs should be separated in the funding model
- Consider the geographical nature of New Zealand and the preference to have services available for older people from rural, provincial and metropolitan areas

What do we mean by ‘funding model’?

- A funding model is a means to allocate money to enable care providers to source and use human, physical and technological resources
- A funding model allocates money based on:
 - Units of purchase
 - Prices for units of purchase
 - Arrangements for payment for units of purchase

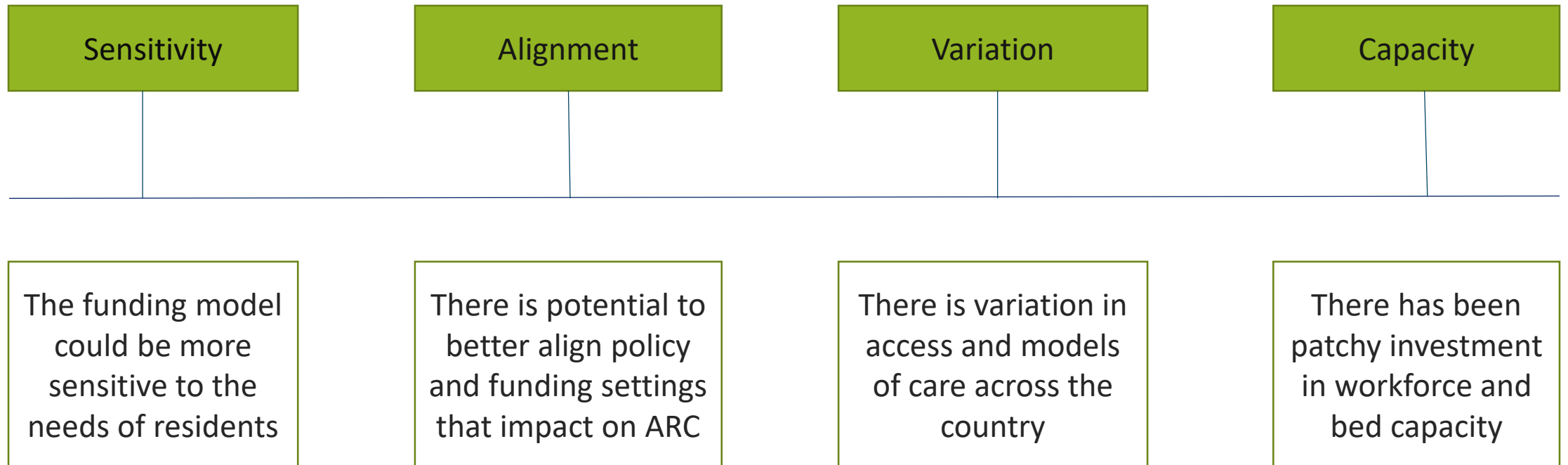
Funding models influence how consumers, funders and providers behave through the incentives they create

Components of the existing ARC funding model

- Resident choice of facility, and provider choice of resident
- Needs-based allocation to one of four levels of care (rest home, dementia, continuing care ('hospital') and psychogeriatric)
- National price for each level of care, with small adjustments based on geographic location of facility ('TLA price')
- Demand driven ('uncapped' budget)
- Subsidised, top-up model. Each resident must contribute to the cost of their care up to a maximum amount, with the remainder of costs being subsidised by DHBs. The subsidy is universal for hospital, dementia and psychogeriatric. It covers the incremental change in contract price between these levels of care and rest home level care
- Nearly all residents make a contribution towards the cost of their care, with the level of contribution based on an income and asset testing regime
- Payment is based on a fee-for service model using a bed-day as a unit of service
- Bed-day price includes accommodation, care delivered by provider staff, equipment needs, availability of on-site amenities and purchasing of other defined health services required for resident care needs (e.g. primary medical care)
- Minimum staffing levels as per national agreements, and 'safe' staffing guidelines
- There are some targeted funding streams that providers can access to assist with managing costs associated with some types of care (e.g. high cost wound dressings, bariatric care equipment)
- Flexibility for providers to:
 - charge extra fees to residents, with some rules;
 - operate a range of business models including retirement living arrangements and ARC
- Flexibility for DHBs to provide local solutions to support appropriate access and quality of care (e.g. respite care and other short-term care; quality improvement programmes)
- Quality and safety managed through:
 - certification;
 - audit;
 - consumer/family choice;
 - DHB performance management.

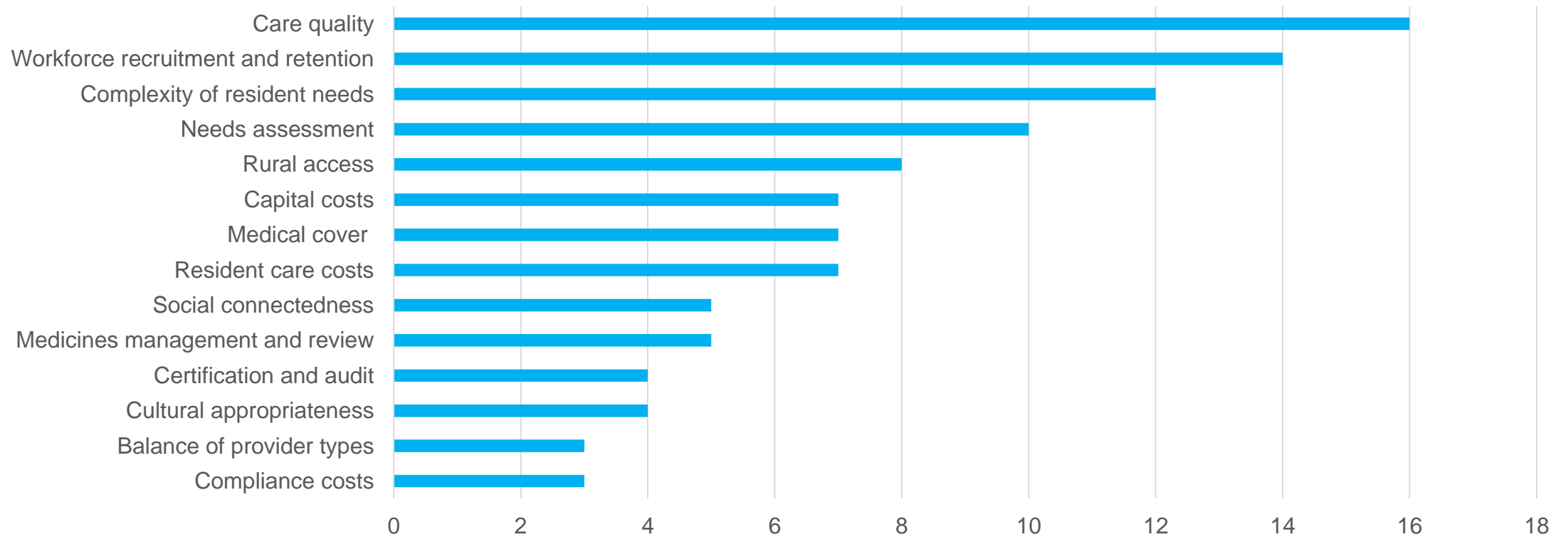
Issues guiding the Review

Four key issues are guiding the Review:



Issues ranked by importance – Round One forums

In the July forums, participants were asked to rank 14 issues in terms of their importance and relevance to the Review:



Issues ranked by importance – Round One forums *cont'd*

The issue statements most commonly ranked as important and relevant were:

- **Care quality.** This was connected to the funding model in two main ways:
 - Providers need to be able to deploy the right resources to deliver quality care, which is linked to pricing and units of purchase
 - How funding is allocated should incentive providers to focus on maintaining or improving the health and well-being of a resident's life
- **Complexity of resident needs** (resourcing for residents with more complex care needs):
 - Forum participants generally felt that ARC providers are managing a more complex mix of residents than 10 years ago, with a significant increase over the past 3-5 years
 - There was a lot of discussion about whether units of purchase and pricing suitably align with the changing cohort of residents
- **Needs assessment.** For some, this related to the need for a funding model to have a robust needs assessment process; for others this related to issues with the use and implementation of interRAI
- **Workforce recruitment and retention.** For some, this issue included primary care and pharmacy workforce considerations, as well as caregiving and nursing staff internal to ARC facilities

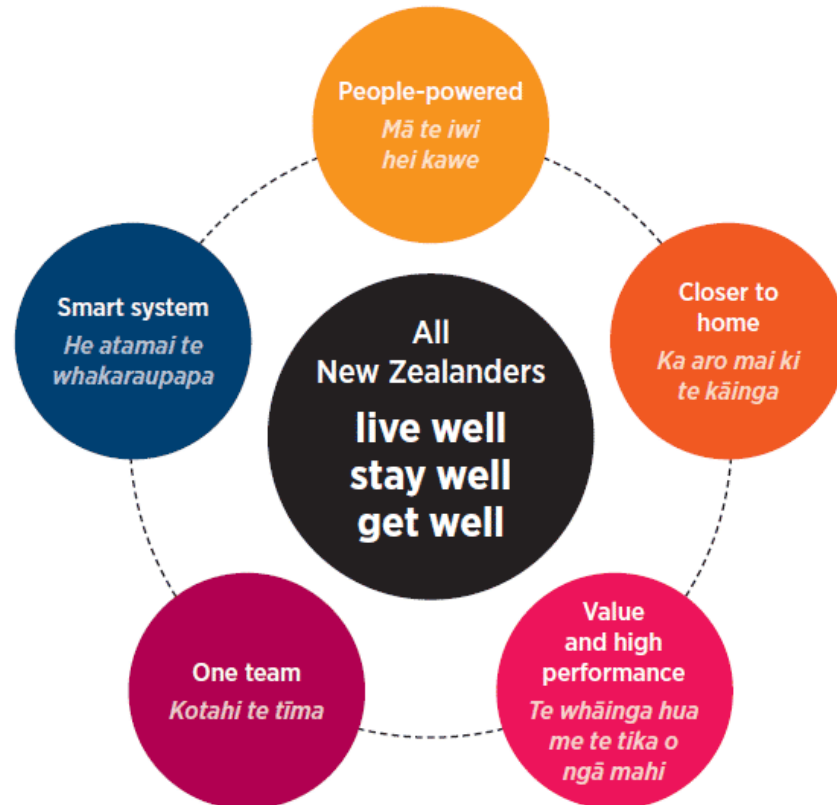
Strategic context, models of care and desired outcomes

System design for ARC

The New Zealand Health Strategy

Vision:

All New Zealanders live well, stay well, get well, in a system that is **people powered**, provides services **closer to home**, is designed for **value and high performance**, and works as **one team** in a **smart system**



People powered – the funding model should be driven by resident needs and should support older people (and their families) to make informed choices about their care options

Closer to home – the funding model needs to support appropriate close to home access to ARC, and needs to recognise ARC as a person's home

Value and high performance – the funding model needs to support a focus on ongoing quality and outcome improvement through the best use of data and evidence

One team – the funding model needs to support ARC providers and wider health services to act cohesively as a team, working together with the resident and their whānau at the centre of care

Smart system – the funding model should support innovation in care models including taking advantage of opportunities offered by new and emerging technologies

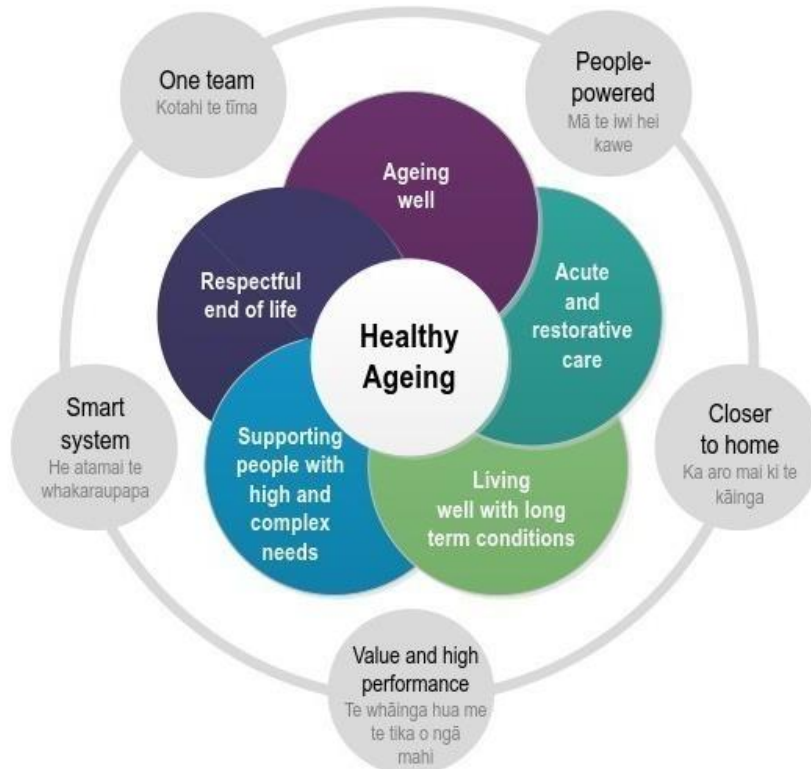
The model of care for ARC

Based on the *New Zealand Healthy Ageing Strategy*

Vision:

Older people live well, age well and have a respectful end-of-life in age-friendly communities

Strategic focus areas

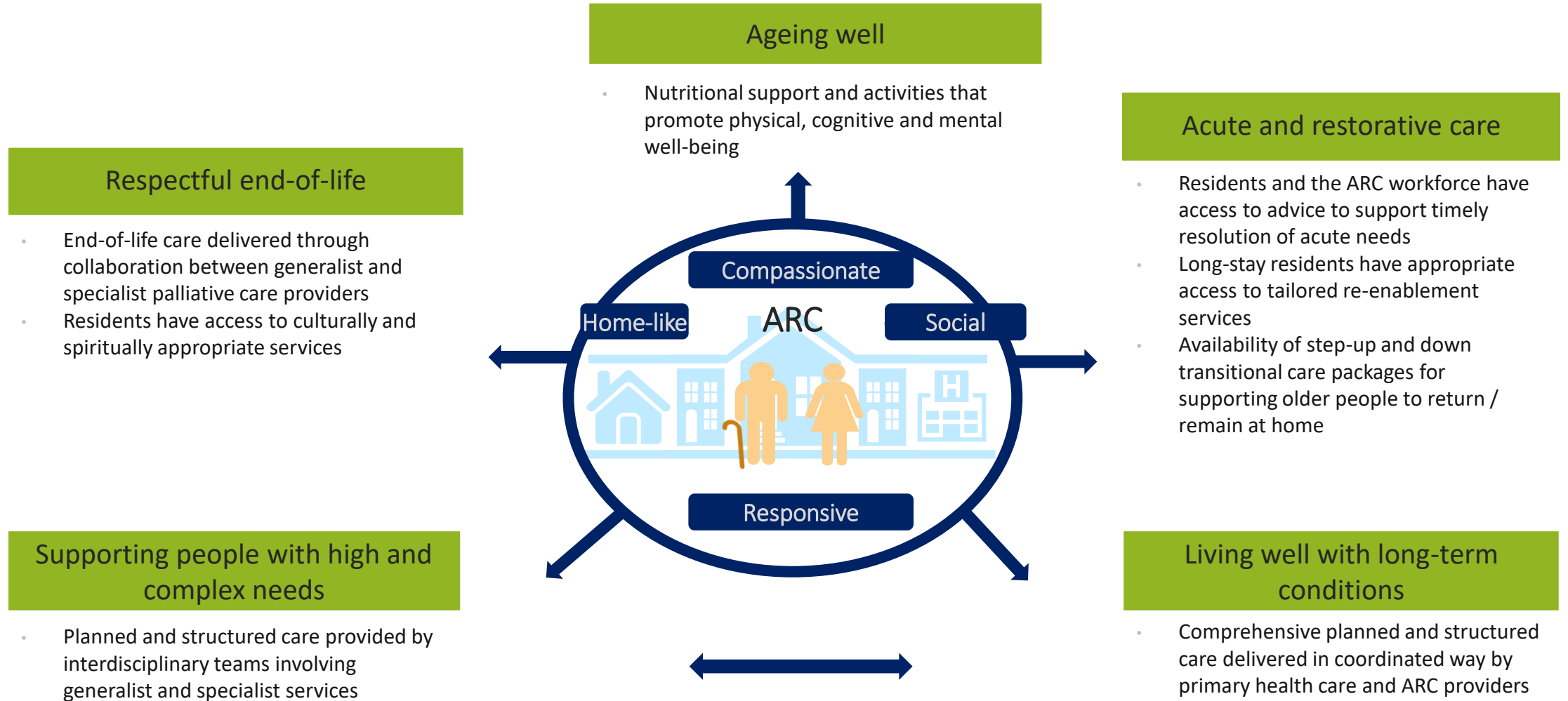


Key themes for aged residential care (ARC)

1. Aged residential care should enable holistic well-being for older people who cannot safely remain at home including a respectful end-of-life
2. Aged residential care should be integrated with health and social services to enable routine and comprehensive care for residents, and timely response for acute needs, with policy and funding settings across services aligned to enable effective care
3. Aged residential care should be integrated with the health system's overall continuum of care, playing an active role in managing acute care needs in the community, and enabling restorative and rehabilitative care close to home

The model of care for ARC

Based on the *Healthy Ageing Strategy*



Outcomes from desired care models

The following statements have been derived based on our understanding of the desired outcomes from aged residential care. You can provide your feedback on these statements in the online survey:

1. Older people and their families have a diverse range of accommodation options to choose from to meet their needs and preferences
2. Older people have equitable access to, and outcomes from, ARC when they require this care
3. Care is resident-centred, and is proactive and responsive to different cultural and spiritual needs
4. Clinical risk is effectively identified and managed across the system
5. The majority of a resident's primary health care needs can be effectively resolved in a timely way within the aged residential care setting – any time of day, and day of week
6. When a resident requires a higher level of care their transition of care is safe and timely within, and to and from, the facility
7. Older people can receive effective rehabilitative and restorative care in ARC settings either as long-term residents or as a transition pathway home

Outcomes from desired care models *cont'd*

8. Older people and their families / carers have options for flexible short-stay and day care arrangements to support ageing-in-place, enabling a greater proportion of older people with less complex needs to remain at home
9. Where feasible and desirable, there is a seamless interface between home support and residential care services
10. The right level and mix of workforce is working in ARC to provide the types of care needed and desired by older people and their families
11. The right level and mix of other health and social services is available to ARC providers to enable holistic care for long and short-stay residents
12. Funders, providers and regulators have clarity about the types of care needed and desired by older people and their families so they can effectively co-operate to achieve viable and affordable solutions

Funding care in ARC

What do we mean by care?

- Resident-related activities and tasks provided by:
 - Nurses, caregivers and activity coordinators
 - Therapy services (e.g. physiotherapy, occupational therapy)
 - Primary health care (e.g., GPs, nurse practitioners, pharmacists)
 - Secondary care
- Care may also include social and participatory activities provided by ARC

Context

- New residents to ARC are older and frailer than they were 20 years ago
- The average age of entry to ARC has continued to increase, and is now 85 years
- The median length of stay is ~18 months*
- The annual mortality rate is ~42%^
- The prevalence of cognitive disorders has increased, with more than half of all residents having some level of cognitive impairment

* Based on Ministry of Health CCPS data using a cohort analysis of people who first entered care in 2012. This excludes maximum contributors in rest home care. It also excludes residents who were admitted for palliative care.

^ As above. The mortality figure is the percentage of residents who died within 12 months of first being admitted to ARC.

Issues with the existing four levels of care

- More based around types of facilities rather than types of residents
- Nearly 50% of residents are in one care level (rest home), with a further 40% in another care level (continuing care hospital) – likely significant diversity of care needs in each level
- Funding is weakly linked to the drivers of care costs
- Some add-on funding supplements have been introduced to accommodate some care costs (e.g. high cost wound dressings). These are at the margin, and reportedly hard / costly to access
- Care pathways and models of care between ARC and other health services are variable by provider and region. There is difficulty in connecting pathways and care models with existing four care levels

Desirable features of funding care in ARC

- The allocation mechanism for placing people into care levels should make sense clinically and for frontline staff
- Care funding should be linked to cost drivers to enable providers to deliver on funder expectations
- There should be fair distribution of funding across providers, recognising differences in resident mix and delivery context
- The allocation of funding should promote best use of resources
- Stakeholders should be able to understand how the funding model works through clear assumptions and approach
- The allocation mechanism should provide sufficient certainty of funding to encourage appropriate investment in workforce and physical capacity, while allowing for evolution in care models

Stakeholder feedback – residents needs / levels of care



* Responses to EY's online forum survey

Four funding model options for care levels

1: Status quo	2: Supplements (e.g.):	3: Further stratification	4: interRAI RUGs (e.g.):
Rest home	Special therapies	Lower	Physical limitations
		Higher	Behavioral problems
Hospital	Special equipment	Lower	Cognitive impairment
		Higher	Clinically complex
Dementia	Bariatric	Lower	Extensive services
		Higher	Special needs
Psychogeriatric	Palliative	General	Rehabilitation
	End-of-life	Individualised	?

Note box sizes do not represent number or proportion of residents, or levels of funding

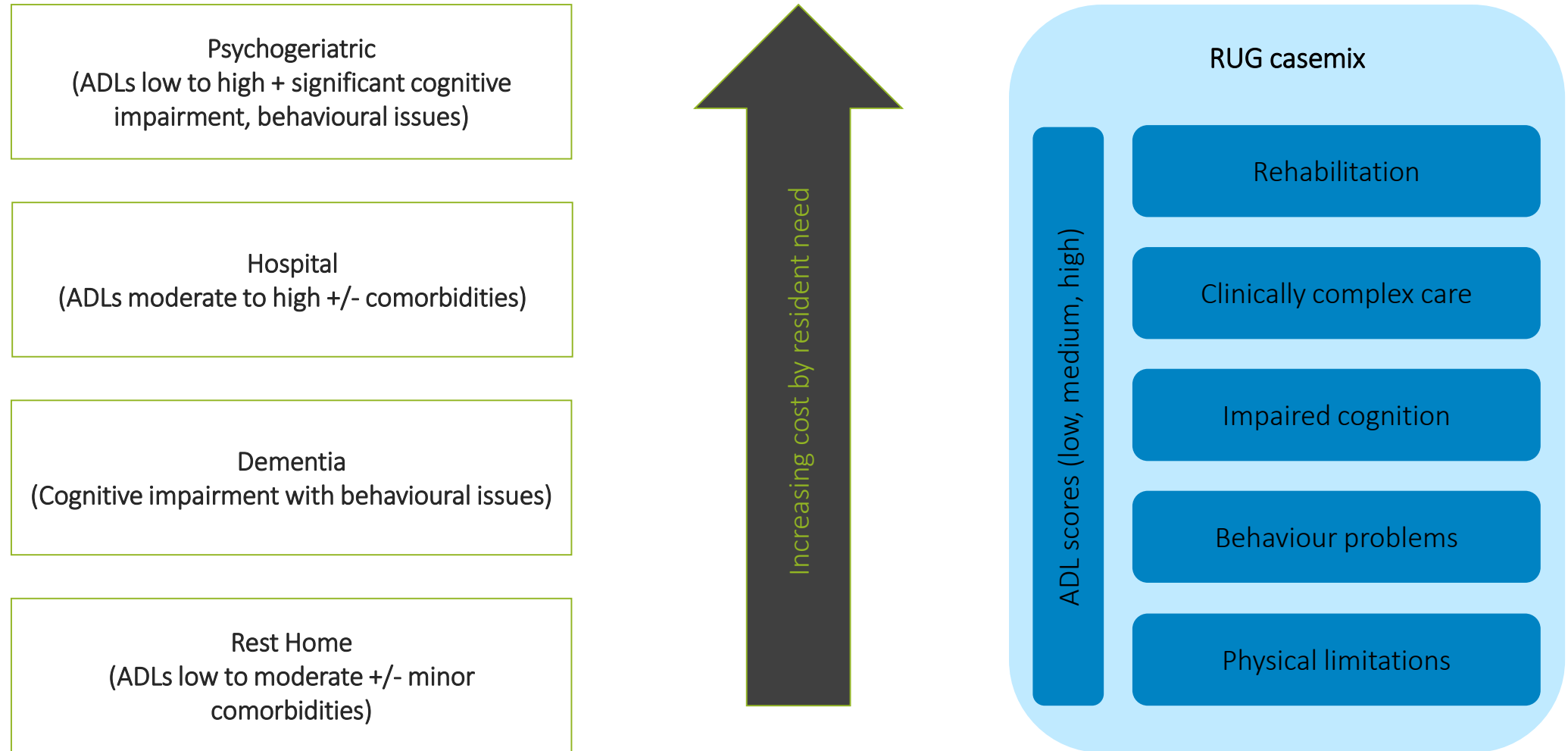
interRAI Resource Utilisation Groups (RUGs)

- Funding is based on relative resident need and associated resourcing using interRAI data and a casemix index
- Residents are grouped into “Lead” categories, which distinguish each group’s relative resource intensity. ADL needs are generally found to be the primary driver of cost differences between residents
- Main resources included are nursing, caregiving, therapy professions, primary medical, and clinical supplies (sometimes including clinical equipment)
- Usually basic services (e.g., catering, cleaning, laundry) and capital costs are funded separately
- The casemix index is derived through analysis of resident needs and resource use over a 24-hour period (nursing, caregiving, supplies) and 7-day period for therapy and professional services)
- A U.S. approach, validated in a number of international jurisdictions (e.g. Canada, Finland, England and Wales, Italy, Switzerland, Korea, Japan)
- Validation studies have looked at how well the approach explains variance in costs between different types of residents

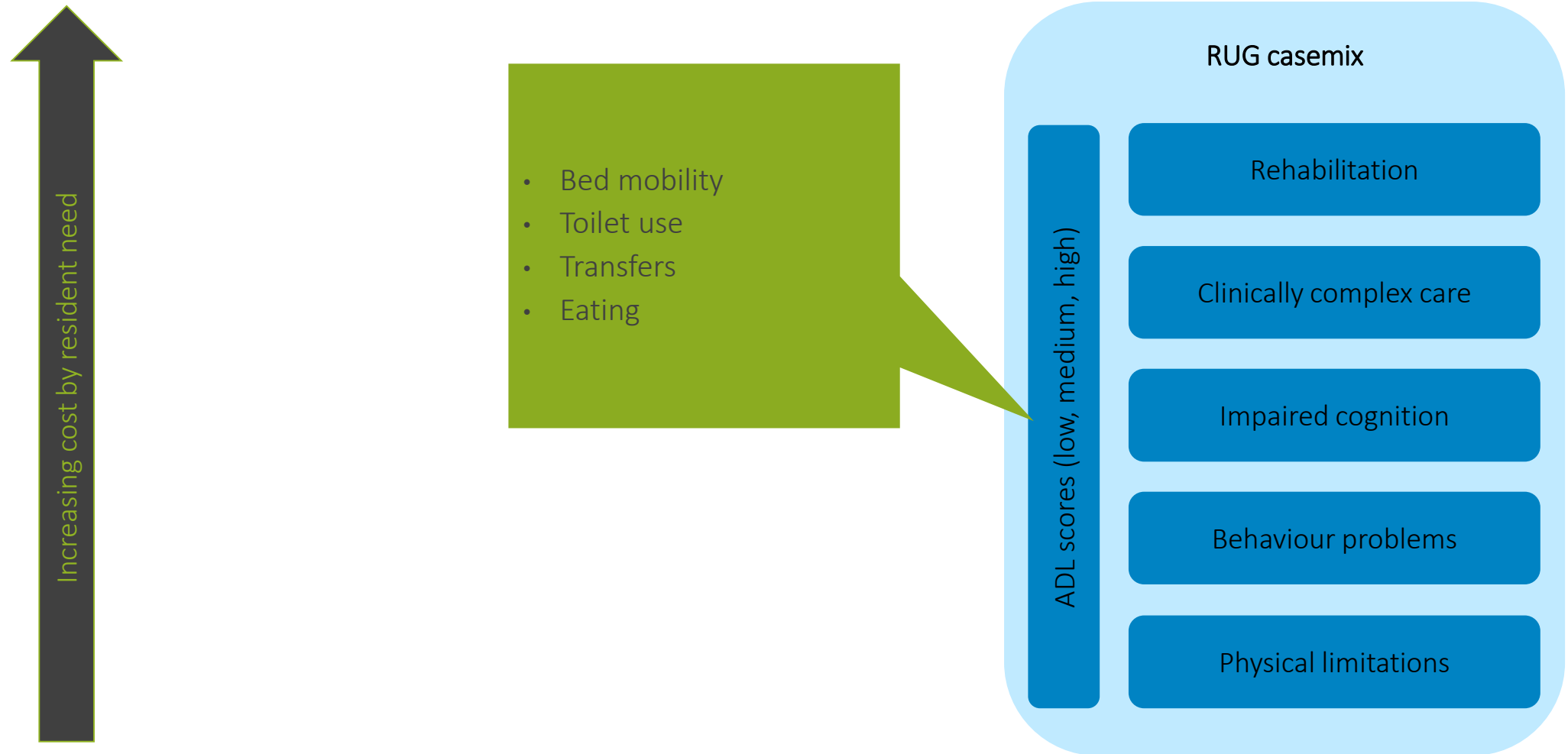
interRAI Resource Utilisation Groups (RUGs) *cont'd*

- The third version of the RUG approach (RUG-III) in the U.S. was found to explain about 55% of variance in costs. International validation studies generally find that it explains somewhere between 30% - 45% of variance in costs. Differences in the wage rate relativities within countries and the role of ARC in the health system generally explain higher and lower variance findings between countries
- The number of lead categories and how ADL scores are used in the funding model can be modified
- A recent study in New Zealand suggested five lead categories and three ADL groups might make sense
- This would produce 15 RUGs, and therefore, 15 prices
- Larger countries tend to have more RUGs as their population size means that there is a sufficient number of residents for statistically meaningful results in more categories
- In some countries long-term care also plays a more extensive role in the health system (e.g. rehabilitation, complex clinical care such as ventilation). This too is generally a function of the size of the country and therefore providers can achieve sufficient critical mass to undertake higher levels of care (e.g. post-op care; ventilation)

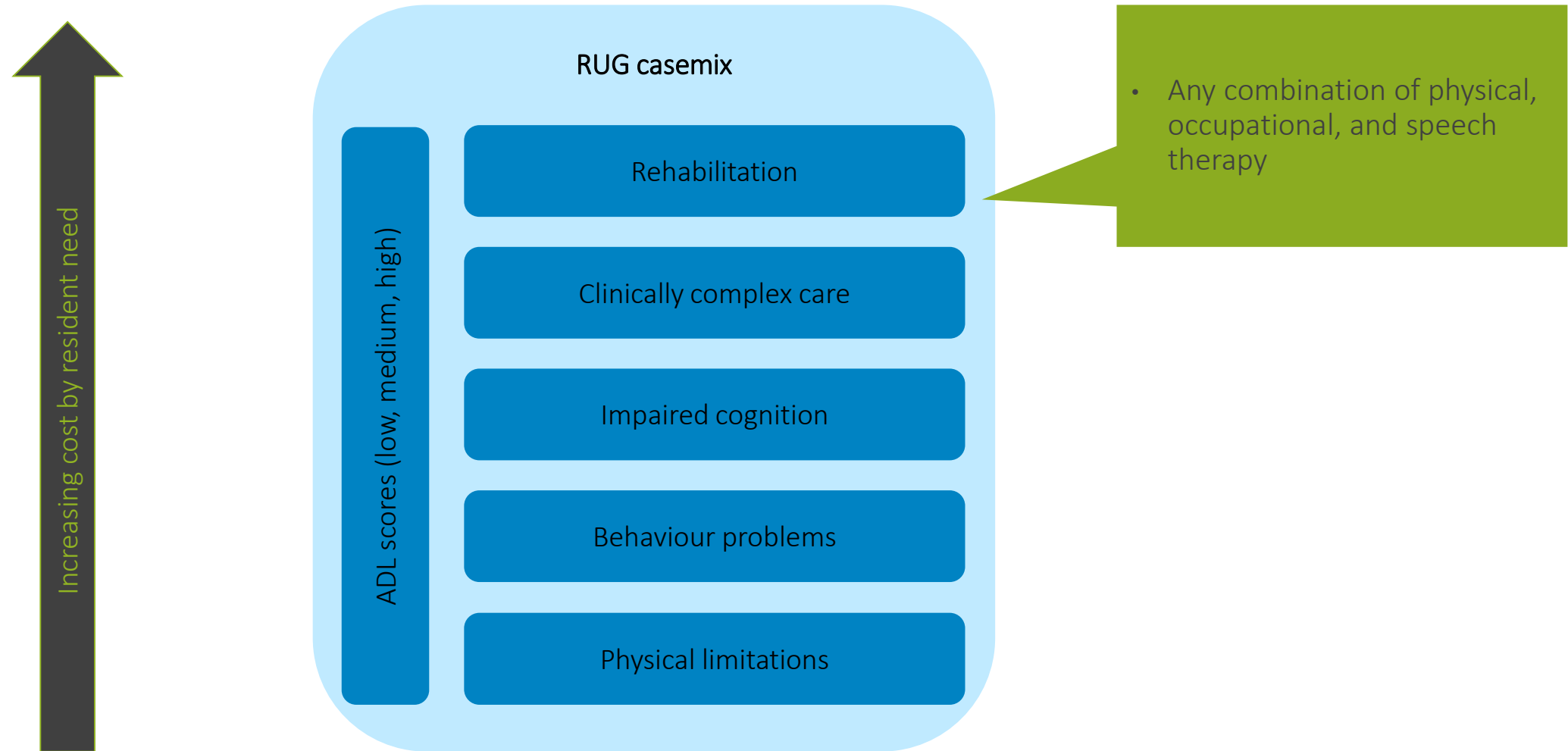
Relationship between existing care levels and RUG approach



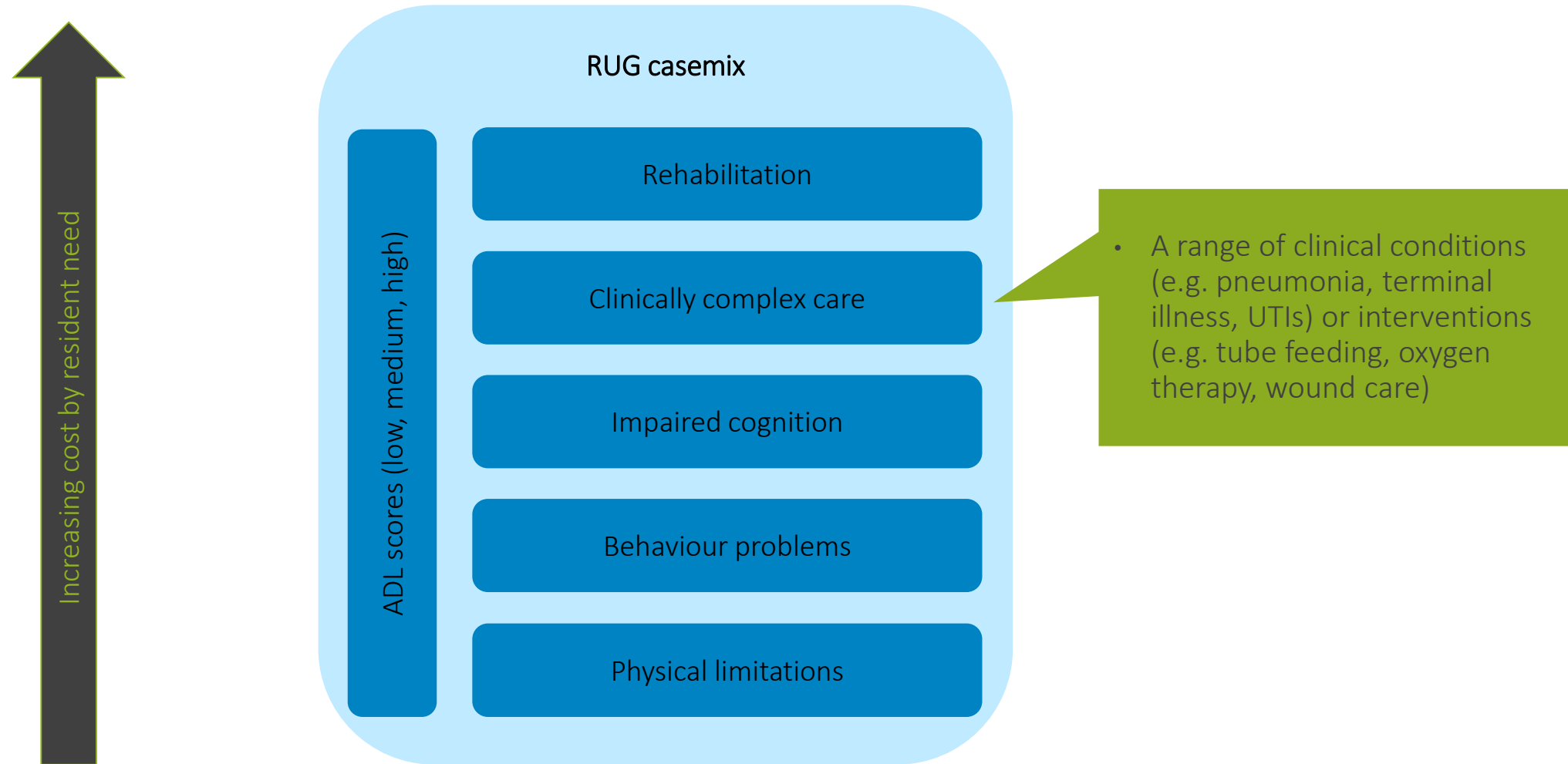
Relationship between existing care levels and RUG approach



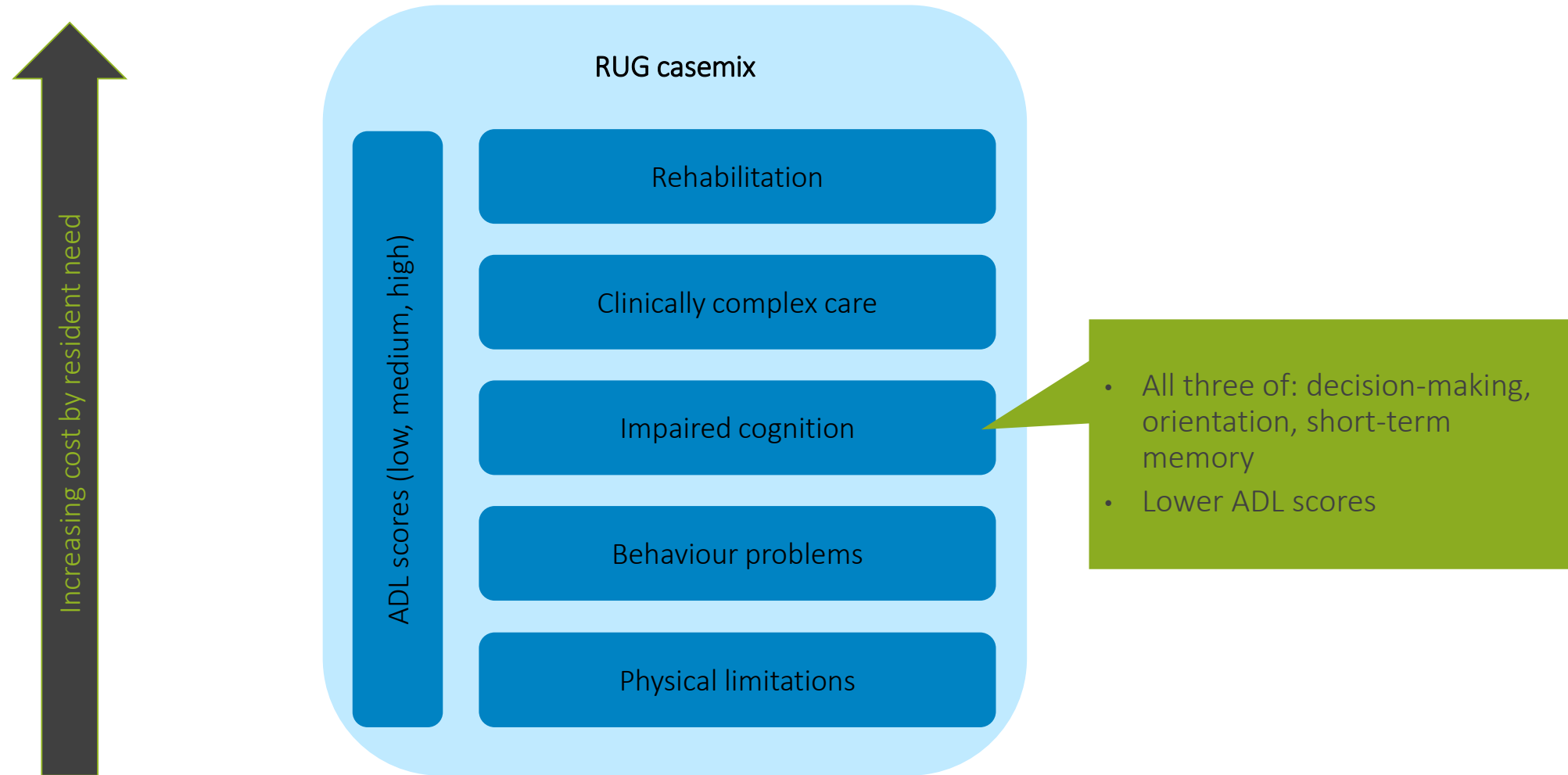
Relationship between existing care levels and RUG approach



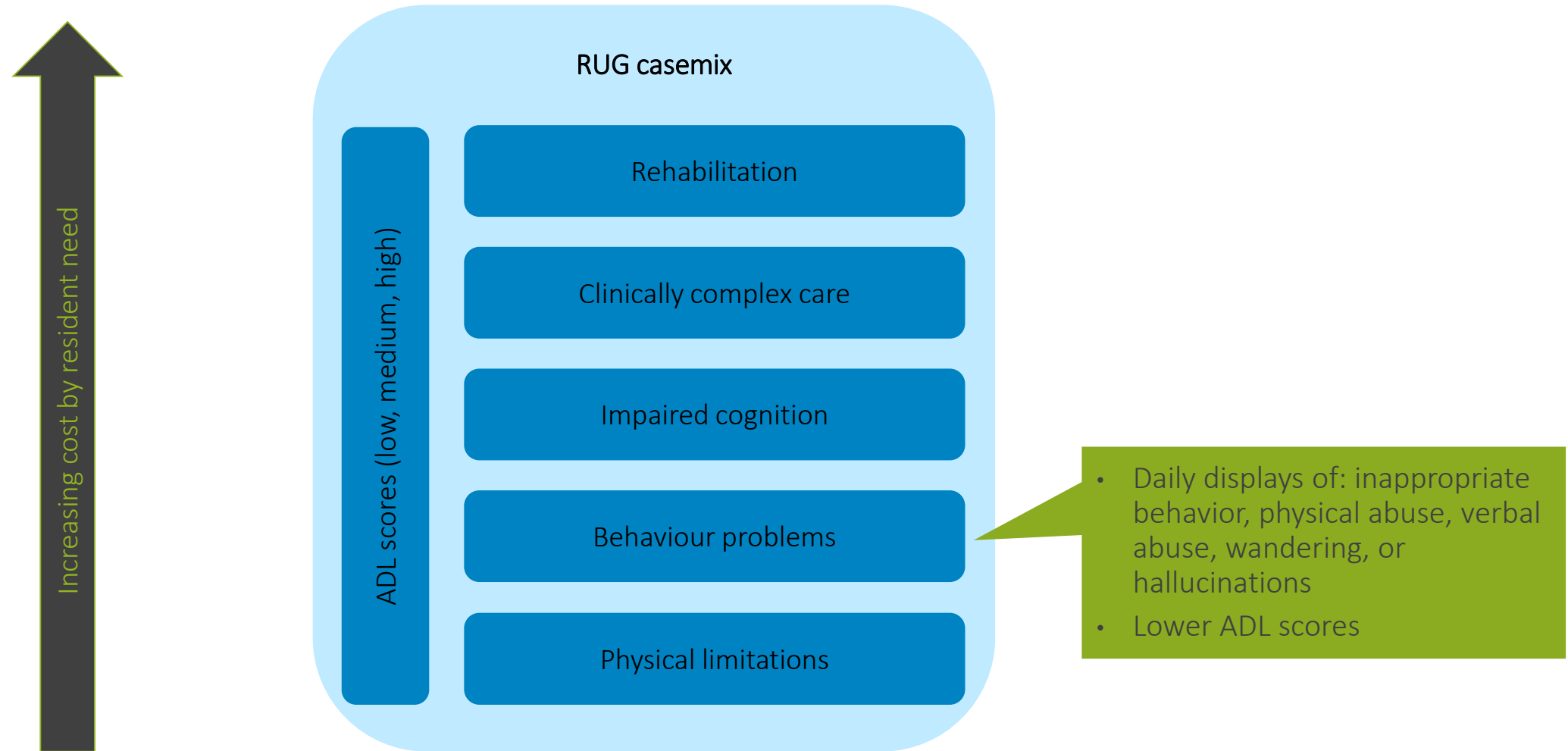
Relationship between existing care levels and RUG approach



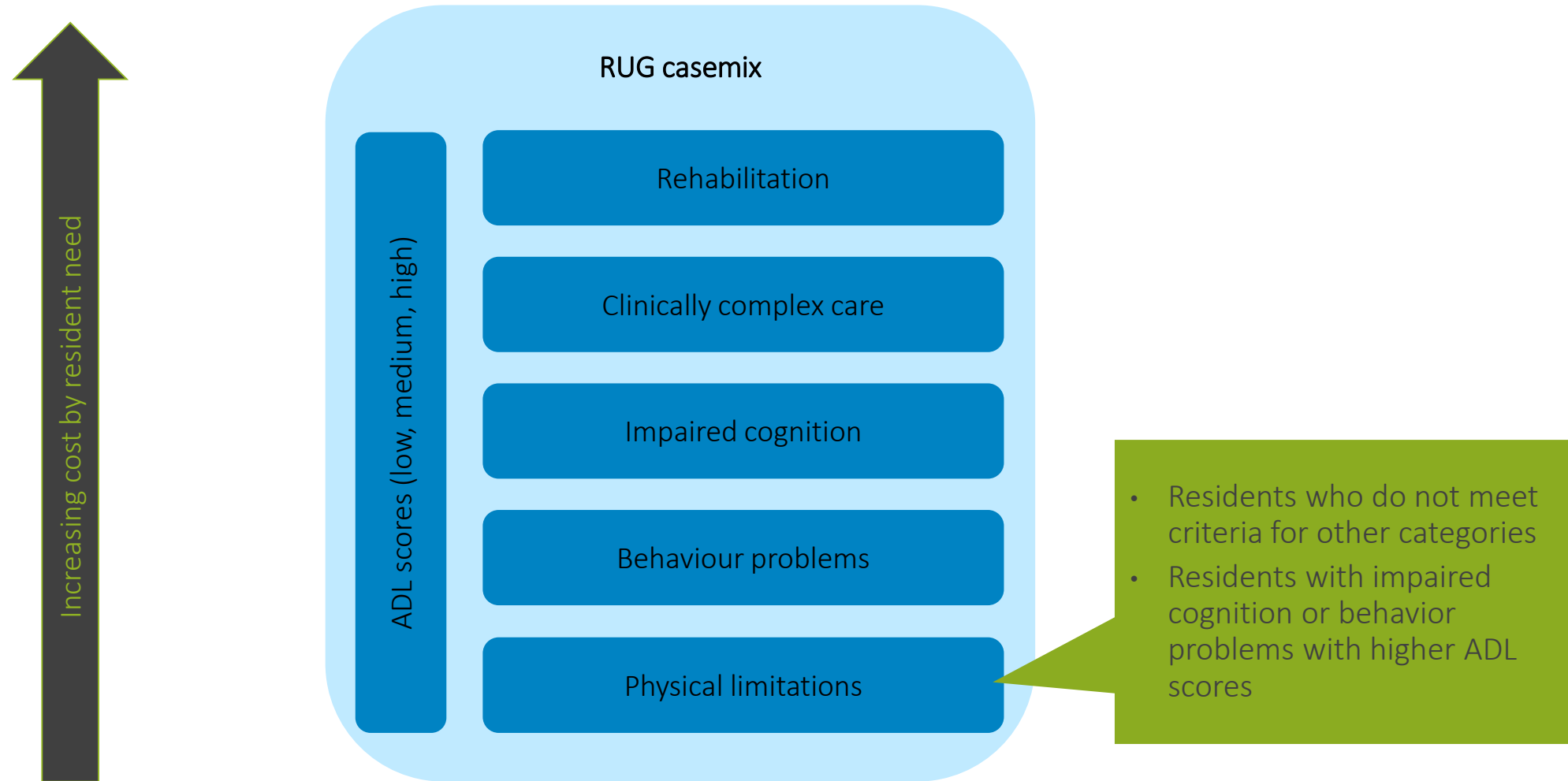
Relationship between existing care levels and RUG approach



Relationship between existing care levels and RUG approach

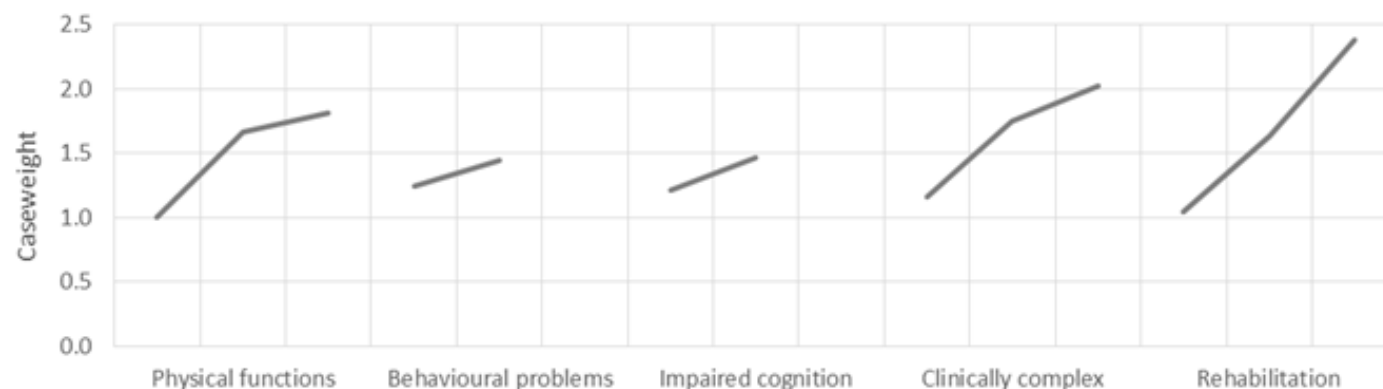


Relationship between existing care levels and RUG approach

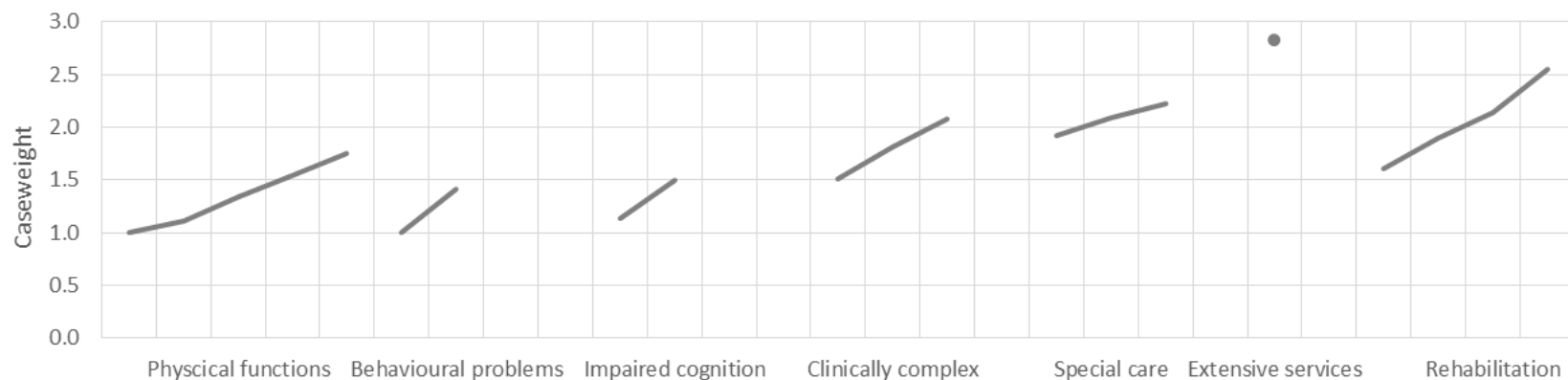


Relative intensity of resourcing by RUG category

Estimated resource intensity by RUG lead category and ADL group (BUPA Foundation NZ study). Caseweights include nursing, caregiver and supplies. To understand the graph, consider one caseweight equal to \$1

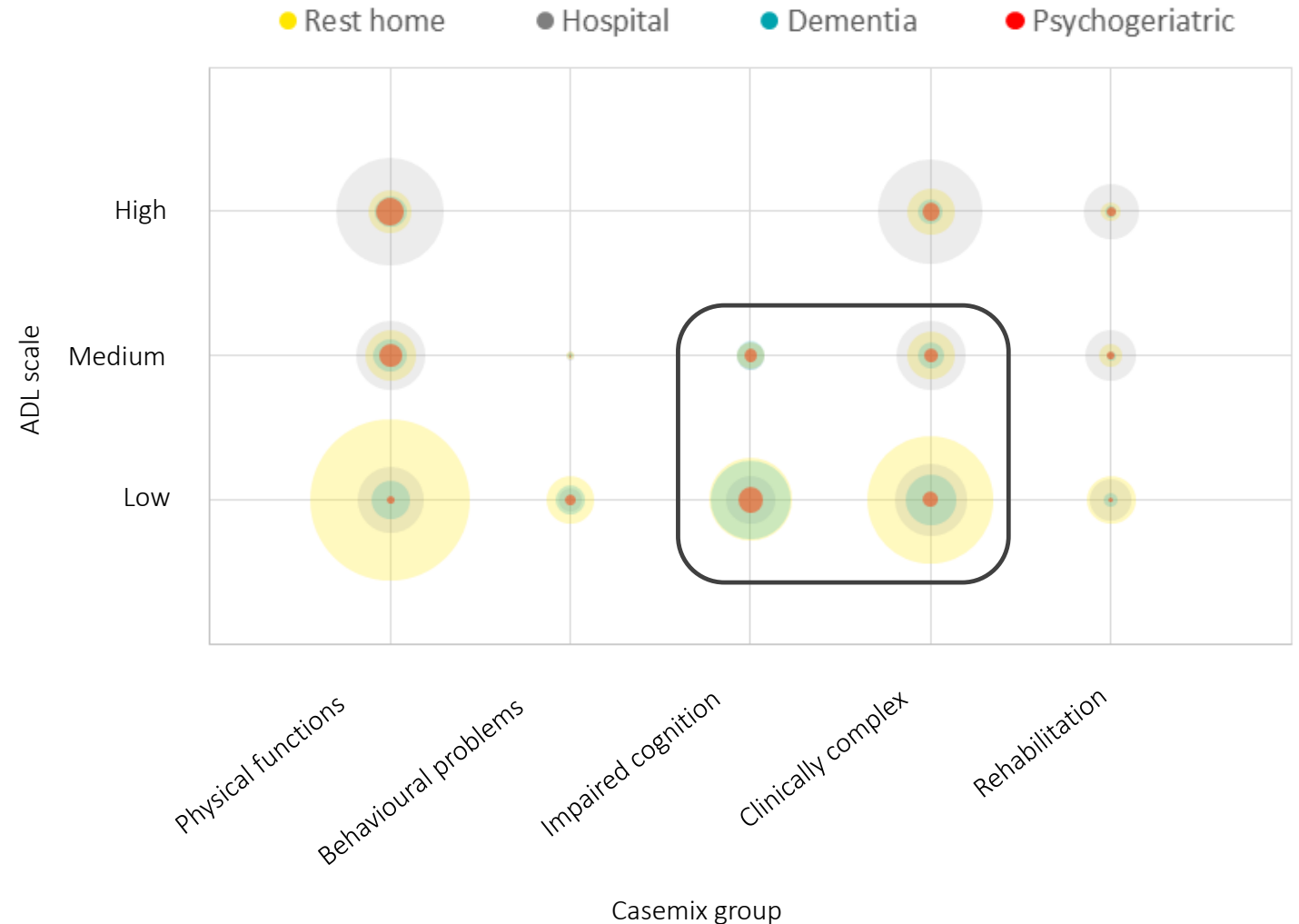


Estimated resource intensity by RUG lead category and ADL group (Ontario – point of reference). Caseweights include nursing, caregiver, supplies and some specialised equipment. Additional lead and ADL categories are included in Ontario

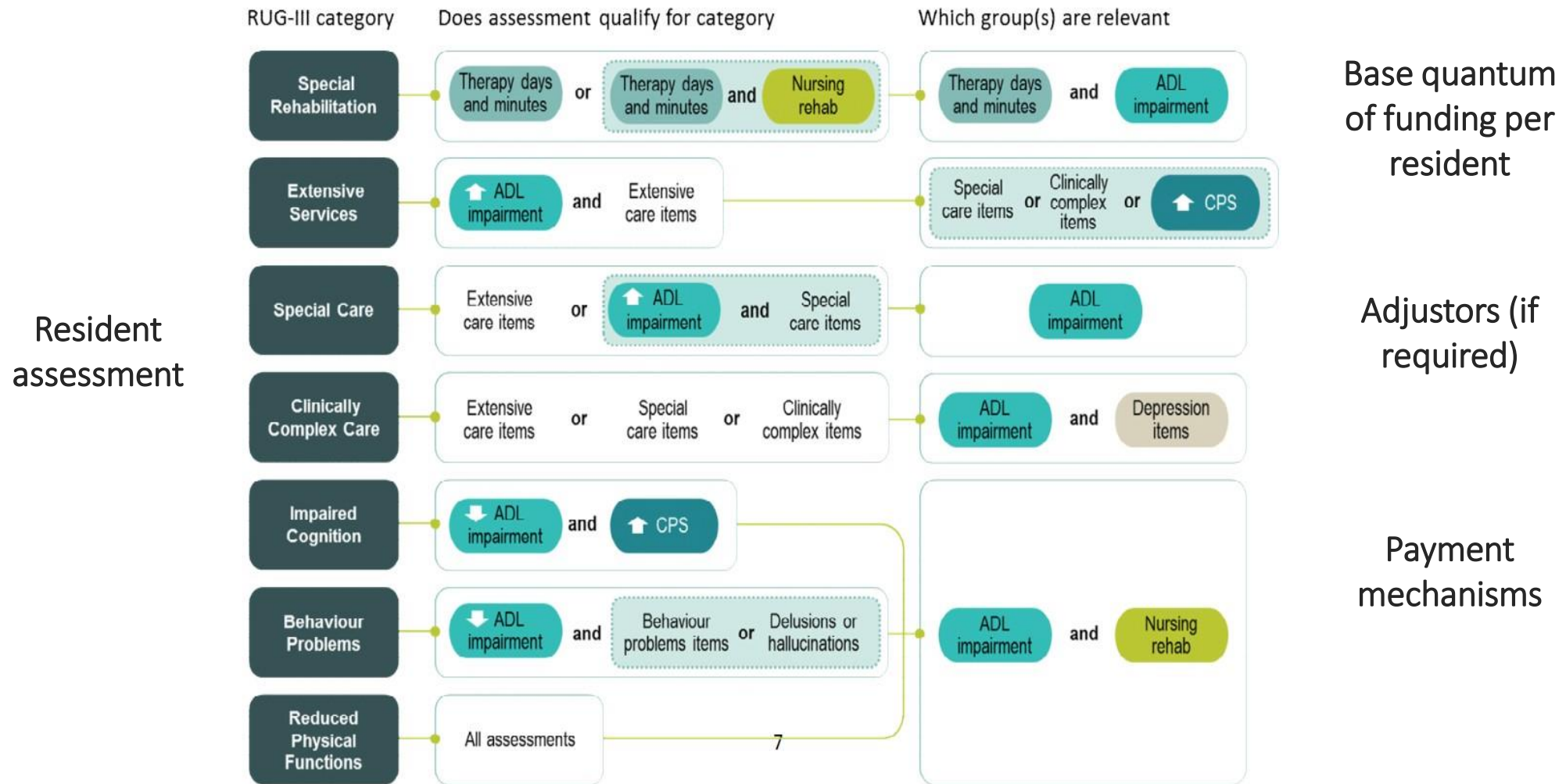


Alignment between existing care levels and RUGs

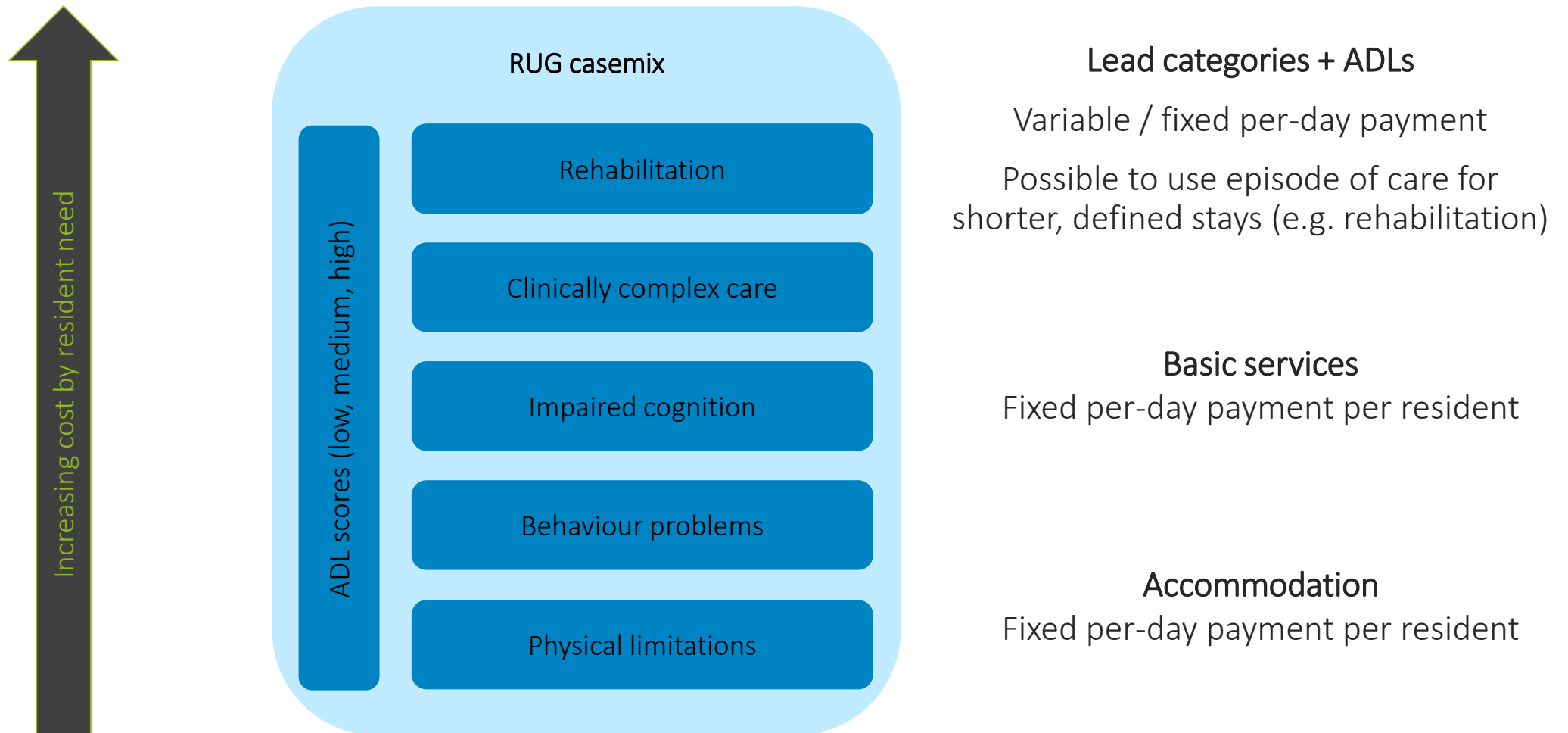
Bubble sizes represent number of individual residents. The RUG lead categories and ADL groups and existing four care levels are overlaid to indicate patterns of allocation in the existing system. The graph suggests that the main overlaps in the current allocation process are for people with lower ADL needs and who have impaired cognition and/or clinical comorbidities. In other words, residents with similar characteristics may be allocated to different care levels, and therefore, providers will receive different prices for similar residents



How the interRAI RUG approach works



Potential funding structure



Opportunities of using a RUG approach

- Better alignment of models of care with resident cohorts of similar clinical needs:
 - Services provided by ARC
 - Services provided by other health and social services (e.g. primary care, pharmacy, allied health)
- Opportunity to drive model of care improvements / innovation through the lead categories
- Alignment with casemix models for home & community support services (“a seamless interface between services”)
- Single funding framework for ‘long stay’ and ‘ short stay’ (e.g., respite, palliative, intermediate)
- More consistency in allocating residents to care categories
- Connecting assessment, quality indicators and funding (based on one core data-set, making best use of data and introducing some self-regulation into the system)

Assumptions

- The RUG approach is more clinically and financially meaningful as it directly connects clinical assessments and variables that best predict resource use
- Increasing the specificity of the funding model will result in a fairer allocation of funding
- A fairer allocation of funding will enable providers to more effectively resource care for all residents in their facility
- A more direct linkage between resident interRAI assessments and funding will improve understanding of and responsiveness to the changing needs of residents
- Improved allocation of funding based on the resource intensity of resident need will enhance access to care
- Increasing physical, cognitive or clinical (or mixture) needs makes it more resource intensive to promote a resident's well-being, and therefore, the RUG approach will better support providers to holistically meet the needs of their residents

You can provide feedback on your views on the RUG approach in questions 7-10 in the stakeholder feedback survey.

Other funding model considerations

Context

- Demand for ARC is expected to increase in the future largely as a result of population ageing, meaning more ARC capacity will need to be available
- In recent years, most new capacity has been developed by more 'premium' providers, and by integrated retirement village / aged care providers
- There is a variance in the quality of infrastructure between facilities, particularly between rural and urban areas
- The accommodation and care preferences of older people are also expected to change as the 'baby boomer' generation ages
- Wealth and income inequality has been increasing in the older population, and home ownership has been falling (slowly) in the 65+ population. Nonetheless 4 in 5 older people own their own home
- New models of care, living environment designs and technologies are emerging
- While innovation is occurring, time, resources, expertise and payback periods can get in the way, particularly for smaller organisations
- Additionally, where costs and benefits of improvement are not clear or are shared unequally across parties, innovation may not occur

The following four pages highlight specific issues that were discussed in the forums. You can provide feedback on these issues in the stakeholder survey, in questions 11 – 17

Particular issue - rurality

- Access to ARC for older people living in rural communities:
 - The funding model currently makes little distinction between geographic regions
 - Non-urban providers tend to:
 - be smaller
 - provide only rest home care
 - report poorer financial performance
 - have older capital stock
 - Population ageing in rural communities is likely to be more intense than in urban settings due to smaller growth of or reduction in the working age population
- Some international funding models have features like:
 - Higher prices paid to rural providers through supplements
 - Block funding
 - Access to capital
- If New Zealand's funding model was to have features to promote rural access, what would be the set of principles that decision-makers could use to guide how the funding would be used? For example, how would a decision-maker decide which providers would be eligible for rural funding arrangements?

Particular issue – balance of provider types

- The funding model currently makes no distinction between:
 - Small vs large provider (in terms of number of beds)
 - Facilities integrated with retirement villages vs standalone care facilities
 - Providers that offer a single care level vs multiple care levels
 - Not-for-profit providers vs for-profit providers
- What level of choice should be available to residents in terms of provider types? What tradeoffs will need to be made to foster this desired level of choice in the sector?
- Should the funding model explicitly differentiate between different types of providers to ensure residents have the desired level of choice?
 - Why?
 - If so, how?

Particular issue – restorative care

- Feedback from stakeholders is that ARC can be a ‘one-way street’ – once someone goes in it can be very difficult to get back out
- In your view, what are the barriers to ARC being a two-way street?
- How can a funding model better support ARC to be a two-way street?
- In particular:
 - How should residents who have the potential to improve their function and return home be identified?
 - How should the means testing regime work in these situations?

Particular issue – premium charging

- Some stakeholders have expressed concerns that access to ARC may be compromised for those with less means due premium charging
- The mix of non-premium and premium rooms, and facilities, has changed over time, with about half of all rooms reported as 'premium' in the recent NZACA Industry Profile
- In your view, should there be more direct incentives for ensuring access to ARC for residents with less means?
- If so should these incentives be based on types of residents or types of rooms?
- What should these incentives include?

**Thank you
for your contribution to
the Review**

Disclaimer

The summary of findings contained in this background information document are based on the findings of the report prepared at the request of Central Region's Technical Advisory Services ('TAS') solely for the purposes of the aged residential care funding model review ('the Review'), and is not appropriate for use for other purposes. This summary is provided for information purposes only in order to provide background context for the Review and should not be taken as providing specific advice on any issue, nor may this summary be relied upon by any party other than TAS. In carrying out our work and preparing this background information document, Ernst & Young has worked solely on the instructions and information of TAS, and has not taken into account the interests or individual circumstances of any party other than TAS.

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