

## ACFI QUESTIONS & ANSWERS

---

### ACAA eBulletins

#### AUGUST 2007 ISSUE

#### QUESTIONS & ANSWERS ON ACFI FROM THE DEPARTMENT OF HEALTH AND AGEING

##### **Respite admissions**

What is the rule regarding re-assessment if someone is admitted as respite but becomes permanent?

*If a person enters care for respite and a decision is made to permanently stay after some time and the person has not entered permanent care from hospital. An ACFI appraisal is to be made within 2 months of the date the person permanently entered care and this classification will not have an expiry date.*

##### **RCS Classification**

An RCS resident currently classified as high care category 1 is confirmed at the highest level under ACFI. How does the application of the \$15.00 minimum increase rule apply?

*An ACFI rate is calculated as the sum of the 3 funding streams. Where this amount exceeds the RCS rate by \$15 or more the person is eligible for a higher rate - even if that is capped to the maximum. By way of example, an S1 resident (\$125.23 per day) is reappraised after 20 March 2008 as being high in all three care domains. The ACFI rate is calculated as \$167.57 which is more than \$15 above the existing RCS rate. Therefore, a higher rate of subsidy is payable but this higher rate is capped at \$10 more than the RCS maximum. The rate payable will be \$135.23 for this person.*

*Policy and Evaluation Branch, Ageing and Aged Care Division, The Department of Health and Ageing, 16 August 2007*

---

#### SEPTEMBER 2007 ISSUE

#### QUESTIONS & ANSWERS ON ACFI FROM THE DEPARTMENT OF HEALTH AND AGEING

##### **Care Awaiting Placement or Transitional Care Centres**

If a residents gets admitted from Care Awaiting Placement or a Transitional Care centre does the direct hospital admission rule apply about re-assessing in 6 months, or to put another way are these admissions considered a direct hospital admission?

*The six month expiry only applies where the resident enters care of the RACS directly from an "inpatient hospital episode". This would mean that the classification would have a six month expiry only if the resident was actually an inpatient while in Transition Care. For all other cases the classification would not expire.*

*Department of Health and Ageing, 19 September 2007*

---

#### OCTOBER 2007 ISSUE

Q: Under Medical diagnosis can a registered nurse enter a diagnosis code in the (other) category?

A: No, a Registered Nurse is not able to diagnose however the RN can fill in the appraisal.

Q: There is a category for the diagnosis from the ACCR many of whom are RNs who complete this diagnosis. So can an RN in the ACF fill this in?

A: The ACCR is considered evidence for the ACFI as it is a requirement under Part 2.3 of the *Aged Care Act 1997* for the approval to receive age care services. Most ACATs are multi-disciplinary teams and some RNs do fill in the diagnosis section. However, they collect their information from various sources including medical practitioners. Following discussions with various parties on this issue it has been decided that only Medical Practitioners can diagnose for ACFI purposes.

---

## FEBRUARY 2008 ISSUE

### ACFI QUESTIONS AND ANSWERS

#### Pre-entry leave while resident is in hospital

A service provider can be subsidised for holding a bed for a person making arrangements to enter a residential care facility from hospital providing the resident holds a valid approval at the start of the pre-entry leave. Pre-entry leave of up to seven (7) days can be claimed for such persons.

An ACFI reappraisal for a resident admitted directly from hospital is due six (6) months from the day the resident enters the care of the approved provider. This will apply even if the person is on pre-entry leave at the time of entry into the care of the approved provider.

#### ACAT low but ACFI high – ACAT reassessment

Where an Aged Care Assessment Team (ACAT) limits the approval of care for a resident to low care and the initial appraisal of the resident's care would otherwise have resulted in a high care classification, the rate of subsidy for the resident cannot exceed an amount to be determined by the Minister for Ageing. This is similar to the current "default S5" rate payable for such residents under the RCS. Should the ACAT subsequently approve the resident for a high level of residential care, the date of effect for the higher care classification is the ACAT approval date.

#### ACAT low but ACFI high – impact on bonds and charges

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

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

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

These legislative provisions will continue to apply after ACFI commences. The Department's approach to this issue would be to treat it as an evidentiary matter. That is, the decision is based on the evidence available regarding the care recipient's care needs **at the time of the person's entry to the service**.

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

The appraisal by the approved provider of the person's care needs for the purpose of classification normally cannot begin until after the period of 7 days starting on the first day when the care recipient enters the residential care service (see subsection 9.17(3) of the *Classification Principles 1997*). This means that the ACFI appraisal, while it might be good evidence of the care recipient's care needs during the appraisal period, would have to be given less weight as evidence of the care recipient's care needs at the time of the person's entry to

the service because it is not contemporaneous evidence.

### **ACFI Progression Rules**

The ACFI rate for a resident is the sum of the amounts payable in each of the three domains. An existing resident will move from an RCS amount to an ACFI amount where the ACFI rate calculated is \$15 or more above the RCS amount. However the amount paid cannot exceed the maximum ACFI rate. Let's use some examples to clarify:

1. A current RCS1 (\$125.23) resident is reappraised after 20 March 2008 as HHH. The ACFI rate for the classification is \$167.57. The maximum ACFI rate from 20 March is \$135.23. As the calculated ACFI rate \$167.57 is more than \$15 above \$125.23, an ACFI amount is payable. However, the calculated ACFI rate of \$167.57 exceeds the maximum ACFI rate of \$135.23 and so the maximum rate is paid (\$135.23).
2. A current RCS1 (\$125.23) resident is reappraised after 20 March 2008 as MHM. The ACFI rate for this classification is \$127.35. As the calculated ACFI rate is not \$15 more than the RCS rate, the RCS 'saved' rate (\$125.23) will be payable for this resident.

As can be seen from example 1, even though the actual increase in rate is less than \$15 due to capping the maximum rate at \$10 above the current RCS1 rate, the higher amount is still payable.

*Complex health - 4a+b – Complex pain managed by an allied health professional*

**Question/Issue:** Please clarify the meaning of "managed". Is there a strict requirement that all treatment related sessions to be administered by an allied health professional (or RN in the case of 4a) OR are they only required to manage the process?

This point is raised as it is common practice in these situations for the allied health professional to assess the resident and to develop and monitor the treatment plan. This plan may involve the allied health professional providing a certain number of sessions per week (say 1 or 2) while a therapy assistant, RN, EN, or carer delivers treatment on the other days.

**Response:** For ACFI 12 (4b), pain management procedures must only be carried out by an allied health professional. If the procedure is given by a registered nurse, only ACFI 12(a) can be claimed.

*Management of chronic infectious conditions*

**Question/Issue:** Please clarify if a resident with an antibiotic resistant bacterial infection such as MRSA or VRE would qualify for this question.

Both MRSA and VRE are antibiotic resistant bacteria that require a modification to management practices (ie stricter infection control procedures).

**Response:** Yes. Methicillin Resistant Staphylococcus aureus (MRSA), diagnosed by pathology testing, is spread in the same way as other staphylococcal infections but can be difficult to treat in residents who are frequently hospitalised, such as the critically ill, residents requiring dialysis and the elderly who are chronically ill. Precautions to prevent and control the spread of MRSA infections may include isolating residents who carry or have MRSA infections with dedicated equipment allocated to the infected resident – including stethoscopes, thermometers etc.

*Management of chronic wounds*

**Question/Issue:** Please clarify the definition of "management". What role does prevention play in the "management" of such conditions?

This question is of some concern as there is a financial benefit possible if care is not well managed and a resident develops a pressure ulcer. Alternatively, providers that manage pressure ulcers well (either by ensuring they don't occur or managing them so they resolve quickly) will be financially penalised for doing so.

Please also clarify the definition of "chronic". Must a pressure area be present for > 3 months for it to be classified as chronic?

Consider the scenario where a resident returns from extended hospital leave (and thus requires a reassessment) with a new (ie 2 day old) Grade IV sacral pressure area. This, by definition can not be considered a "chronic" wound (as it has only been present for 2 days), however there is a significant increase in the resident's care requirements.

**Response:**

*Definition of 'management and its role in preventing such (chronic) conditions as pressure ulcers*

ACFI 12 Complex Health Care relates to the assessed need for ongoing complex health care procedures and activities with a mandatory requirement for a diagnosis (or ACCR reference) - therefore a medical assessment is required.

While there is no exact ruling of when a wound becomes chronic, the inclusion of the three main categories of wounds (venous, diabetic and pressure wounds) can be used as a guide. A health professional must be appropriately qualified to develop the directive for a procedure to manage the health care activities. The person *performing* the care need assessment must be a Registered Nurse.

Therefore, in order to score a 3 in this question, there needs to be:

1. appropriate evidence in the ACFI Appraisal Pack (Diagnosis or ACCR); and
2. a directive (registered nurse or medical practitioner or allied health professional); and
3. a care need assessment.

*Management of ongoing stoma care*

**Question/Issue:** Technically a stoma is an opening which connects a portion of the body cavity to the outside environment. Can a PEG be considered a stoma? The care of a PEG stoma is equivalent to the care requirements for a colostomy site.

**Response:** Yes. Usually a stoma is formed by surgery, eg. a colostomy is an opening or the formation of an opening into the colon. A stoma can be temporary or permanent.

Care of the individual with a disorder includes preventing and managing altered elimination, the promotion of comfort, maintenance of skin and mucous membrane integrity, can be claimed under ACFI 12 Checklist item 15 management of ongoing stoma care – including a PEG – requires staff to maintain hygiene of appliances, skin and stoma wafers etc.

---

## **MARCH 2008**

### **Email between ACAA & DoHA**

#### **ACAA**

In the Residential Care Subsidy- Basic Subsidy Amount Determination 2008 it states:

10 (2) (a) The basic subsidy will be normal or late RCS / ACFI rate for the day that is before the 31st day of the care recipients leave

10 (2) (b) The rate will be at half [50%] of the basic subsidy for the day that is after the 30th day.

This would stipulate the reduction kicks in on the 31st day of hospital leave.

In the explanatory Statement it states:

Section 10 Extended Hospital leave when a recipient has taken leave for a continuous period of 30 days or more

This would stipulate the reduction kicks in on the 30th day of hospital leave. [This is also how the extended hospital leave is currently legislated]

Also another point of interest is the noted in the fact sheets sent by the Department is that 2 medical practitioners can authorise LOW to HIGH ACAT approvals. I can not see anything in the amendments that states anyone but an ACAT can authorise.

#### **DoHA**

We had identified this as a potential issue a couple of days ago. I can confirm that the extended hospital leave provisions kick in on the 30th day - not the 31st. I will be discussing this with our drafters to confirm whether any amendment to the Subsidy Determination is required.

The Fact Sheet is picking up on current policy which is why it is not in any amendments. The *User Rights Principles* currently state that 2 medical or other health practitioners may approve under s23.5(4)(b) rather than the ACAT. This is not a low to high issue but is instead around whether a home can ask a resident to move to another service because it can no longer provide the care the person requires.

---

#### **Copy of email correspondence received from department 20<sup>th</sup> May 2008**

As per the ACFI User Guide (p.34), ACFI 11 Medication relates to the needs of the person for assistance in taking medications administered on a regular basis. Infrequent or irregular administration of medication(s) is not covered in this question.

Medication refers to:

- any substance(s) listed in Schedule 2, 3, 4, 4D, 8 or 9 of the Standard for the Uniform Scheduling of Drugs and Poisons (and its amendments) and / or
- medication(s) ordered by an authorised health professional or authorised for nurse initiated medication by a Medication Advisory Committee or its equivalent. This excludes food supplements, with or without vitamins, and emollients (e.g. sorbolene cream, aqueous cream, etc).

Therefore, so long as the medication has been ordered by the authorised health professional, is needed on a regular basis and the person requires assistance to complete the ingestion by the route ordered, the approved provider may claim on this question. Whether or not the medication may be purchased over the counter is not relevant to the claim.