painaustralia

PROPOSAL FOR NEW AGED CARE FUNDING INSTRUMENT CONSULTATION

MAY 2019

Proposed new aged care funding model:

Painaustralia welcomes the opportunity to provide a submission to the Department of Health's consultation on the proposed new aged care funding model, the Australian National Aged Care Classification (AN-ACC)

Painaustralia is the national peak body working to improve the quality of life of people living with pain, their families and carers, and to minimise the social and economic burden of pain. Members include pain and other specialists, health practitioners, health groups, consumers and researchers. Painaustralia works with our network to inform practical and strategic solutions to address this complex and widespread issue. The issue of safety and quality of care across aged care is an important one for us and our members. The consequences of untreated pain not only impact the individual person, but there is greater distress to their families and a greater care responsibility for staff.

Over a million older Australians (65 years and over) live with chronic pain, with rates almost twice as high as the working age population.[1] It is estimated up to 80% of aged care residents have chronic pain,[2,3] but more than half of residents in aged care facilities in Australia have a diagnosis of dementia as well which suggests a high proportion of people with chronic pain also have cognitive or communicative impairment and inability to report pain.

Chronic pain is a common condition among consumers of aged care services and effective pain management should be a core responsibility of all providers. Unfortunately, evidence suggests many people with pain are poorly treated or under-treated.

In the Australian Pain Society's (APS) Pain in Residential Aged Care Facilities (2nd Edition: 2018), it is noted that the current Aged Care Funding Instrument (ACFI) is prescriptive, rigid and not based on sound clinical assessment or best practice. The APS note that this creates financial incentives favouring passive treatments to manage pain rather than evidence-based, active treatments. They recommend a model which would be able to support resident independence and engagement and allow for preventative interventions, exercise, falls prevention and an emphasis on mobility, function as well as providing care to people to do daily tasks.[4]

Overall, Painaustralia is supportive of the proposed AN-ACC and the three main components of the proposed new funding model:

a. a fixed payment for shared costs,
b. a variable payment for individual resident costs; and
c. an adjustment payment for entry costs.

Our submission is focussed on the practical implementation of the new funding model, in particular the variable and adjustment payment for individual residential costs and other issues that must be factored into funding considerations.

Recognising the prevalence of chronic pain in Residential Aged Care:

As the consultation paper notes, the staff time data collected in the Resource Utilisation and Classification Study (RUCS) indicated that close to 50% of staff time was spent delivering care tailored to the specific needs of the resident.

Over a million older Australians (65 years and over) live with chronic pain, with rates almost twice as high as the working age population.[5] With an estimated 80% of aged care residents living with chronic pain,[6,7] and more than half of residents (52%) in aged care facilities in Australia also living with a diagnosis of dementia while two in three (67%), the high-level of care required to manage chronic pain in residential aged care is well documented.[8]

As noted in our submission to the Royal Commission into aged care, the data suggests a high proportion of people with chronic pain also have cognitive or communicative impairment and inability to report pain.

While chronic and acute pain is common among residents of aged care facilities, the evidence suggests that pain is misunderstood, poorly managed or undertreated, including the suboptimal use of analgesics.[9]

Evidence also shows that people with dementia in particular are living with pain and are being under-treated compared with cognitively intact persons, despite having similar levels of potentially painful disease.[10]

In one study, pain was detected in just 31.5% of cognitively impaired residents compared to 61% of cognitively intact residents, despite both groups being equally afflicted with potentially painful disease.[11]

Chronic pain and BPSD, Mental Health linkage:

The prevalence of acute and chronic pain among those with dementia should be recognised as a significant factor in severe behavioural and psychological symptoms of dementia (BPSD), which may be caused by the expression of emotion or unmet need that the person with dementia cannot otherwise express, e.g. pain, frustration, fear.[12]

People living with dementia have shared stories of an aged care system unable to meet their needs with reports of incidences that span physical, psychological and sexual abuse; inappropriate use of restraints; unreported assaults; and people in extreme pain at end-of-life not having access to palliative care.[13]

Untreated or poorly treated chronic pain can perpetuate the pain condition and severely reduce function and quality of life. It impacts personal relationships and can have profound emotional and psychological ramifications. For many people, feelings of anxiety, sadness, grief and anger related to pain can create a burden that is difficult to manage and may lead to the emergence of mental health problems. Major depression is the most common mental health condition associated with chronic pain, with rates of 30% to 40%, and there are also high rates of generalised anxiety disorder and post-traumatic stress disorder.[14]

These statistics are especially concerning in light of research by the National Ageing Research Institute that more than 50 percent of those living in aged care facilities have either anxiety or depression or both disorders, and just under 50 percent enter residential care with a pre-existing depressive condition.[15]

Chronic pain and incidence of mistreatment and neglect in residential aged care:

Cognitive or other communicative impairments of residents, inadequate training of aged care staff with day-to-day responsibilities for residents and workload that prevents adequate pain assessment are all barriers to effective treatment.[16] It can also lead to inappropriate use of physical or chemical restraints[17], misuse of pain medications and reliance on antidepressants.[18]

It is unsurprising that in 2016-17, the most common complaints made to the Aged Care Complaints Commission about residential care related to medication administration and management and falls prevention and post-fall management.[19]

Chronic Pain and Variable Costs within the proposed new model:

The consultation paper currently does not attribute enough weightage to the incidence of chronic pain management within residential aged care. In outlining the factors found to drive individual care, the paper outlines end of life needs, frailty, functional decline, cognition, behaviour and technical nursing needs.
While the paper notes that the most costly residents (on a daily basis) are those who either enter the facility specifically for palliative care or are in a class that are not mobile, have lower levels of function, higher risk of pressure sores and other compounding factors such as behavioural issues, it does not note chronic pain, an issue that is common across all the other identified risks, and infact often a significant marker for high care needs.

This has been a concern Painaustralia has also noted with the new Aged Care Quality Standards. For instance, we are concerned to note that the new aged care quality standards do not acknowledge or consider the high risk and prevalence of chronic pain, despite nearly 80% of residents in residential aged care reporting chronic pain and despite the clear need for providers to have specialist capacity to manage pain appropriately, as often under or poor management of pain can lead to significant adverse outcomes for residents.

Pain not assessed well, not assessed after an intervention, simply asking the person doesn't help, they know the staff are busy and don't want to bother them. Stronger drugs are always the option and an option that leaves them as zombies too.

-carer of person in residential aged care

It is important that the implementation of the new AN-ACC consider the major role pain management plays in both the fixed, and variable costs of providing residential aged care.

In particular, it is vital to recognise pain as a compounding factor within the AN-ACC case mix classification system.

Addressing Chronic Pain through the Adjustment Payment component:

As the consultation paper notes, this component of the new funding model is payment that recognises the additional, but time-limited, resource requirements when someone initially enters care. One of the time-limited additional costs is facilitating health care arising from assessment e.g. pain management.

As identified earlier in our submission, with the prevalence of chronic pain in residential aged care sitting at over 80%, pain management cannot be classified as a time-limited resource requirement, and it is certainly not sufficient to expect that a one-off payment that relates only to an initial admission into residential aged care will be adequate to manage the pain management needs of residents.

The evidence now shows that given chronic pain's individual effects, interdisciplinary assessment and treatment may produce the best results for people with the most severe and persistent pain problems. This can include non-opioid medications, special physical exercises, psychological approaches such as Cognitive Behaviour Therapy and techniques for how to self-manage and mitigate pain. All these approaches require a sustained and systematic funding model that recognises the role chronic pain plays as a compounding factor within residential aged care.

It is important to consider where and how pain management is addressed through the new funding model. The role of pain management needs to be explicitly identified and highlighted, as it can be open to varying levels of interpretation.

This was particularly noted on the ground through the implementation of funding freezes the ACFI in 2016, which saw the reduction of subsidy for the complex health care supplement and ended up particularly impacting high-needs residents with complicated pain-management regimes. This eventually led to the removal of essential pain management services such as necessary physiotherapy and palliative care and diminished the capacity of the sector to provide appropriate levels of pain management in aged care. It is vital to be very clear around how we incentivise and promote pan management through the new funding model.

The proposed classification assessment tool and process:

Painaustralia is supportive of the provisions under the AN-ACC model, which would ensure that care planning is still undertaken by the facility but the assessment for funding is undertaken by an external and independent assessor.

We particularly support and endorse AHSRI's recommendations that external assessors should be credentialed registered nurses, occupational therapists or physiotherapists who have experience in aged care and have completed approved assessment training.

Conclusion

While access to pain management is acknowledged globally as a fundamental human right and the Australian Government recommends best-practice care for aged care residents, Australia's aged care facilities are falling woefully short of effective pain care.

A significant number of residents have pain that is under-treated and are suffering unnecessarily (particularly those with dementia or other cognitive impairment), something that could be avoided through appropriate workforce education and training and adequate regulatory reform of the accreditation and funding system.

Painaustralia strongly recommends that the Department of Health recognises the prevalence of pain among residents of aged care and its role as a compounding factor across service delivery.

We hope our submission provides the Department with the evidence and impetus to prioritise pain management as an important element of aged care, as well as the proposed new funding model.

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Mailing address: PO Box 9406 DEAKIN ACT 2600
Phone: 02 6232 5588
Email: admin@painaustralia.org.au
Website: www.painaustralia.org.au