Australian College of Nursing

CONSULTATION ON THE PRICING FRAMEWORK FOR AUSTRALIAN PUBLIC HOSPITAL SERVICES 2020-21

Australian College of Nursing (ACN) submission to the Independent Hospital Pricing Authority (IHPA)

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General Comments

The Australian College of Nursing (ACN) welcomes the opportunity to provide feedback on the Independent Hospital Pricing Authority (IHPA) Consultation Paper on the Pricing Framework for Australian Public Hospital Services (2020-21). ACN has consulted membership to formulate a response to IHPA's consultation questions.

ACN supports moving the health system towards a patient-centred, outcomes-focused and value-based health care system. Essential elements of these principals are the coordination of care across health care settings (integrated care), open access to patient data (both service and outcomes related) being both compatible and portable between health care providers and a move away from episodic volume-based healthcare.

With the move to integrated care beginning to be coordinated by Primary Health Networks and Local Health Networks, it will be important to be able to measure patient outcomes using classification systems and other tools that are closely aligned. It is appropriate that the ANACC classification system being developed is compatible with the development of primary health care datasets using the same terminology to describe the same conditions. ACN is strongly supportive of collection of data through establishing an Individual Healthcare Identifier (IHI) and measurement of PREMs, PROMs etc., to allow ease and efficiency in decision-making as well as measurement of patient outcomes.

ACN believes that a pricing mechanism that accommodates the move to emerging bundled payment models, such as the *Health Care Homes* trial and the Victorian *HealthLinks: Chronic Care* program, would enable these models to better focus on the continuum of care across health care settings and over the course of a patient's care journey. Rather than focusing on episodic care, the pricing mechanism should accommodate patient treatment modes and transitions in care such as in-home monitoring, telehealth, the handover of care to a patient's primary healthcare provider(s) and the coordinated treatment of patients with multiple morbidities.

ACN has provided more specific responses to the consultation questions below.

Consultation Questions

<u>Question 1:</u> Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?

ACN believes the Pricing Guidelines are relevant in guiding IHPA decision-making processes for hospitals, comprising block and activity-based funding (ABF). The Pricing Guidelines articulate the policy intent behind the funding reform for public hospitals. However, there are a few important caveats, as the pricing guidelines are presently limited to the current ABF system.

The 'Process Guidelines' section includes the guideline 'Evidence-based: Funding should be based on best available information'. ACN believes that in addition to this, research and innovation should be funded to find and apply new methods and overcome hurdles of emerging trends. Health is an every-changing industry; therefore, it would be wise to consider new and innovative methods.

Activity-based funding (ABF) and block funding have certain limitations which need to be taken into account. The section on 'ABF pre-eminence' needs to be clearer about where ABF is practicable because as research shows ABF can have significant limitations.

According to an information paper series by University of Wollongong[1] there are some hospital activities that cannot be classified and counted and thus cannot be funded under the ABF system, include:

- Teaching (E.g. medical, nursing, allied health)
- Learning (E.g. intern, resident and registrar medical training, student nurses)
- Research
- Services for boarders (E.g. a mother staying at the hospital while her child is an inpatient)
- Patient travel (E.g. isolated patient travel schemes) and medical retrieval services (E.g. air ambulance)
- Support for affiliated agencies (E.g. hospitals that prepare food for Meals on Wheels)
- Public health and health promotion services (E.g. healthy lifestyle programs, parent education for new mothers)
- Interpreter services
- Aboriginal liaison and support.[2]

Moreover, nationally agreed classification system needs to be developed to be able to use ABF for these other services[3]:

- Emergency department services.
- Sub-acute care (both inpatient and outpatient) such as rehabilitation and palliative care.
- Out-patient services.
- Hospital outreach and post-acute care services.
- Mental health.

[1] Reference: Eager K 2010, 'ABF Information Series No. 1 What is activity-based funding?', Centre for Health Service Development, University of Wollongong, https://ahsri.uow.edu.au/content/groups/public/@web/@chsd/documents/doc/uow082633.pdf

[2] ibid

[3] ibid

Furthermore, there are a few emerging themes around hospital pricing and funding following the maturation of Activity Based Funding (ABF), that require attention in the discussion. These are *Open access to data, Value-based Care, Patient-centred focus to health funding and Integrated Universal Care.* These themes are interlinked and support one another.

Open access to data is of high importance to the future of health care. Currently many projects are being undertaken to gather different aspects of a patients' data as well as data from various health settings and health professionals. This will allow transparency, aid in data analysis, inform policy decisions, and enable better integrated health care as well as accurate and efficient delivery of funds. Both, accessible data and integrated care, support a value-based health care system where the focus is on patient outcomes, instead of volume fixed price healthcare.

ACN supports a value-based approach to health care funding, where key stakeholders are given financial incentives to cooperate in introducing standardised tracking of health outcomes and costs of care. This allows for a focus on patient outcomes and increasing value to patients, through use of open data and integrated care.

Question 2: Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support value in hospital and health services?

ACN supports the IPHA's suggested addition to the Pricing Guidelines:

> ***Promoting value:*** *Pricing should support innovative and alternative funding solutions that deliver efficient quality care with a focus on patient outcomes. (page 6)*

ACN strongly supports the inclusion of 'value' in hospital and health services as a part of the pricing model. We would support the statement being stronger by removing the word "should" so that it reads "Promoting value: Pricing supports innovative and alternative funding solutions that deliver efficient quality care with a focus on patient outcomes".

Furthermore, ACN suggests IHPA review the wording in other parts of Pricing Guidelines to be more supportive of and aligned with the new addition 'Promoting Value', as well as other aspects of value-based health care and patient-outcomes focused care.

ACN has established a *values-based health care working party* to establish a policy position which considers health outcomes that matter to patients relative to the resources or costs required. A report by the All-Party Parliamentary Group on Global Health outlines the need to develop nursing so that nurses can achieve their full potential which will have the triple impact of improving health, promoting gender equality and supporting economic growth[4]. The current funding model in Australia limits nurses from working to their full scope of practice. A funding model focused on value-based health care will support nurses, our largest professional health workforce, to achieve better universal health care coverage and ensure healthier communities.

[4] All-Party Parliamentary Group on Global Health: Triple Impact – how developing nursing will improve health, promote gender equality and support economic growth; London, 17 October 2016. Accessed 10 July 2019 at https://www.who.int/hrh/com-heeg/digital-APPG_triple-impact.pdf?ua=1&ua=1

Question 3: What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?

Nationally consistent classifications allow the use of ABF for particular groups of activities that can be measured. Classification methods classify and provide costs for activities for different types of patients. Provided below are few points to consider from ACN membership when developing the Australian-Refined Diagnosis Related Group (AR-DRG) classification system Version 11.0 and it's three standards ICD-10-AM, ACHI and ACS Twelfth Edition are:

- Chemotherapy coding does not consider time factor – major / minor for acuity of regimen.
- Codes for care delivery for preoperative cases whom care is required within the hospital setting due to social and environmental factors.
- Codes for community service provision that prevents a patient being sent to an emergency department / admitted.
- Inclusive codes for palliative care community services provided by a public hospital – terminal phase acuity – increased in nursing staff hours and service provision.
- Codes for cardiac patients (awaiting bloods at 4 hour and 8 hour intervals) within an emergency department that does not have a 24-hour / short stay ward.
- Coding for readmissions within 28 days of surgery that the cause of readmission was not associated with the surgery / separate diagnosis.
- Coding for mental health patients whom are accommodated in the emergency department greater than 24 hours or 72 hours.

Question 4: Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

ACN membership proposes the following to be considered in the admitted acute care classification development process:

- Expand admitted acute care to include paediatric specific outcomes / care.
- Mental health care.
- Child and adolescent care.
- Adult inpatient care.

Question 5: Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?

ACN membership believe there are a few impediments to implementing pricing using the AECC Version 1.0 for emergency departments:

- Education of Nursing and Medical staff within the emergency department with set timeframes.
- Acceptable diagnostic guidelines provision within the triage.
- Diagnostic related groups to be set and nurses cannot add to the specific groups.
- Isobar format of handover to change to nursing / medical diagnosis – communication to hospitals.
- Time limitations will be required to change from the 4-minute current triage time, as more specific information is required, patient factors for diagnosis.
- There may be a delay to see patients due to the time factor.

- Current Patient presentation maybe simple as based on triage scores though presentation will increase in complexity based on diagnostic group/s.

Question 6: Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

ACN believes Mental Health Care should not be funded using Activity based funding. So far there is no classification system that is nationally consistent and covers all areas of Mental Health. Mental Health Care should be funded on a patient-outcomes and value-based method. International experience, particularly in the Netherlands, also teaches us not to continue down the path of ABF in Mental Health Care due to the many issues that arise as a result[5].

The NSW Mental Health Commission also expressed concerns regarding use of ABF for Mental Health Care, as well as a report that provided 17 recommendations to properly implement putting ABF in place[6]. The NSW Mental Health Commissioner Mr Feneley stated, "In NSW we still direct more than half our total mental health spending to in-patient treatment – more than any other state, and much more than the evidence says is appropriate," he said. "ABF is based on episodes of service, and in-patient stays are easier to count. It would be a disaster if the new system subtly favoured hospitalisation because of this."[7]

Question 7: Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

It has been suggested by our members to note the following points regarding adjustments:

- Patients in the emergency department where there is no short stay ward, patients require blood tests or radiology prior to discharge.
- Rural and remote hospitals where patients awaiting RFDS where there is no short stay unit, patients are treated in the Emergency Department for specialised care, ward beds at a premium due to patient flow.

Question 8: Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

ACN does not have any objection to phasing out of the private patient correction factor, as it is no longer necessary.

Question 9: Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?

ACN supports transparency through public availability of the NBP. Open access to data will serve evidence-based decision making for policy and planning. ACN believes IHPA must commit to transparency and accountability whilst maintaining patient confidentiality protection, through de-identified data.

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[5] De Jong G 2018, 'Activity-based funding in mental health: a disastrous path', Australas Psychiatry, vol. 26(1), pp. 27-29, doi: 10.1177/1039856217716293.

[6] Mental Health Commission NSW 2017, 'New Approach to Mental Health Funding", https://nswmentalhealthcommission.com.au/news/commission-news/new-approach-to-mental-health-funding

[7] ibid

ACN also strongly supports IHPA's intention to develop public reports on subjects that are relevant to IHPA functions under the National Health Reform Act 2011 (Cth).

Question 10: What are the estimated costs of collecting the IHI in your state or territory?

Although ACN is not in a position to provide estimated costs of collecting the Individual Healthcare Identifier (IHI) in a state or territory, ACN strongly supports the collection of IHI data. The collection and usage of this data has many benefits to the health system. ACN is particularly supportive of classification systems pricing mechanisms that accommodate the move to emerging bundled payment models. ACN believes this data being collected as well as classification systems being developed should be compatible with the development of primary healthcare datasets (PHC Data Asset by AIHW), using the same terminology to describe the same conditions.

Many data collection and analysis projects are currently being introduced in certain areas of health such as Primary Care, Aged Care and Hospital data. ACN believes that to take full advantage of these data assets, it is very important that they speak to one another in regard to terminology, software compatibility, as well as accessibility and sharing of knowledge.

Anecdotally, many databases and information systems do not speak to each other, making integration or national datasets that are interoperable, impossible to achieve. Australia has made significant investments to improve its data linkage capabilities over the past two decades, however there is substantial variation across the country. For example, published outputs on the use of linked administrative hospital data is dominated by Western Australia and New South Wales (Tew et al. 2017).

The Population Health Research Network (PHRN) was established in 2009 as an Australian Government collaboration. It has built nationwide data linkage infrastructure to enable existing data from around Australia to be brought together and made available for research (PHRN 2019). The integration of Commonwealth data can only be undertaken by accredited integrating authorities, which include the AIHW, Australian Bureau of Statistics, Australian Institute of Family Studies, Department of Social Services, Queensland Government Statistician's Office and the Centre for Victorian Data Linkage (Australian Government 2019).

The Australian Government also recently appointed an interim National Data Commissioner with responsibilities for implementing a simpler data sharing and release framework, and better realising the economic and social benefits of increased data use, while maintaining public trust and confidence in the system (Australian Government Office of the National Data Commissioner 2018). The Australian Digital Health Agency (ADHA) is currently pursuing the development of a roadmap for national health interoperability (ADHA 2019a).

Question 11: Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?

ACN is supportive of collection of IHI data by all jurisdictions and acknowledges that this data collection will result in some significant costs. ACN supports a value-based approach to health care funding, where key stakeholders are given financial incentives to cooperate in introducing standardised tracking of health outcomes and costs of care. To ensure high quality, equitable and accessible health care, transparency and quality measures must be in place that show if reforms are achieving intended outcomes. Robust, real-time, linked data, through national minimum data sets,

are needed both within and across care systems to inform the development of performance measures focused on health outcomes, along with routine monitoring of those outcomes.

ACN recognises the benefits of having an Individual Healthcare Identifier (IHI) to support alternative funding models such as bundled payments and value-based care funding models and therefore supports an incentive payment or other mechanism to assist in achieving an IHI. IHPAs work on the bundled pricing approach for maternity care is a good example of the limitations of not having an IHI in Australia. There are some long-term chronic conditions which would benefit from a single price per patient to cover the treatment of a condition across multiple services, episodes and settings of care.

Nursing is the largest, single health profession in Australia with the role of the nursing workforce varying as the remoteness of this workforce increases. In the most remote communities, nurses can often be the only health professional providing regular face-to-face health services within the community. The implementation of bundled payments and value-based care funding models in Australia is integral in achieving value-based patient centric models of care and would support nurse led models of care aimed at achieving health outcomes that matter to patients whilst considering the resources or costs required.

Question 12: What initiatives are currently underway to collect patient reported outcome measures (PROMs) and how are they being collated? Question 13: Should a national PROMs collection be considered as part of national data sets?

ACN strongly supports the possibility of looking into Patient-Related Experience Measures (PREMs) and Patient-Reported Outcome Measures (PROMs) data in the future. PROMs allow us to capture a person's perception of their health, validated generic and disease specific tools, as well as measurement of symptoms, distress/anxiety and unmet needs. While PREMs capture a person's perception of their experience with health care or service.

This data is likely to provide great insights and guide the future of healthcare. Reporting on patient experiences allows patients to provide direct feedback on their care to drive improvement in services, enhancing care co-ordination, communication and case management.

There are many ways of collecting this data e.g. surveys, focus groups, patient stories or journey, and observation. Nurses will be integral to the implementation of PROMs through observations and data collection and in mapping a patient's journey.

Research shows advantages of PREMs and PROMs to include:

- Improvement in detection of worsening symptoms.
- Providing information that may otherwise have been missed.
- Improvement in outcomes and reduction in dropout.
- Ensures voice of service user (patients) is heard.
- Provides transparency with value-based health care outcome measures.
- Benchmarking purposes and open to the public / clinicians.
- Outcomes data for treatment-based care - operative care by speciality, outcomes, effectiveness, quality and quantity based data analysis.
- Contribute towards a more patient-centred view of health system performance.
- Enhance quality and safety or the services provided.

- Help increase understanding of relative effectiveness of different treatments and interventions.
- Enhances processes in the patient-clinician interaction.

Initiatives to collect PROM data

Interest is growing in strengthening and coordinating efforts to collect PROMs and PREMs for the benefit of patients and the health system as a whole. These measures have thus been included in the scope of the new Australian Health Performance Framework (AHPF) as measures for potential development to inform assessments of the appropriateness and safety of care in particular[8].

States and territories have led significant work in this area to drive continuous quality improvement in the hospital and health service sector, including:

1) The Australian Institute of Health and Welfare (AIHW) is developing a ***National Primary Health Care Data Asset***. The purpose of this data asset is to gain a better understanding of the patient's journey and experiences within the health care system. PREMs are an identified data gap in this data asset. Although, population surveys of patient experience are becoming better, there is still need for more sources.

   There needs to be a national data asset that is inclusive of PREM and PROM data, and compatible with other data collections. The AIHW National PHC Data Asset is a strong and useful resource. ACN recommends collaboration between the PHC Data Asset and hospital data assets to have a unified resource.

2) The ***Agency for Clinical Innovation (ACI) Patient Reported Measures (PRM) Program*** is currently being implemented in 11 proof of concept sites across NSW as a key enabler of the NSW Health Integrated Care Strategy[9]. The purpose of the Proof of Concept sites is to demonstrate the feasibility and acceptability of using PRMs.

3) The Victorian Agency for Health Innovation (VAHI) implements a patient experience survey throughout Victoria's public health care agencies, with results analysed and reported to health services and the Agency each quarter for quality improvement. VAHI has also announced it is delivering a pilot PROMs approach in 2019[10].

4) In Western Australia, the Patient Opinion website is being used as an independent feedback platform for all WA health services. The public can publish their experiences of local health services, with health service staff then able to interact with these patients through the website to help improve care[11].

5) Some private health insurers are also measuring and reporting patient experiences. For example, Medibank surveyed members and asked about nine aspects of their hospital stay, as well as their 'likelihood to recommend' and a rating of their overall stay. Results are published online, by hospital (Medibank 2019).

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[8] Australian Institute of Health and Welfare [AIHW] 2018, 'Australia's health 2018', Australia's health series no. 16. AUS 221. Canberra: AIHW, https://www.aihw.gov.au/getmedia/31d2844d-323e-400a-875e-e9183fafdfad/aihw-aus-221-chapter-7-17.pdf.aspx

[9] Agency for Clinical Innovation 2019, 'Patient Reported Measures – Program Update', https://www.aci.health.nsw.gov.au/make-it-happen/prms/program-update

[10] Victorian Agency for Health Information 2018, 'Developing a new approach for collection of patient-reported outcomes', https://www.bettersafercare.vic.gov.au/news-and-media/developing-a-new-approach-for-collection-of-patient-reported-outcomes

[11] Department of Health Western Australia 2019, ' Patient Opinion', https://healthywa.wa.gov.au/Articles/N_R/Patient-Opinion

6) Collation of a yearly survey report regarding ward, emergency, maternity and paediatric inpatient setting patients and questioning on safety and quality, food, access to care.

7) Localised PROM from day surgical units interviewing patients 48-72 hours post-operatively regarding service, outcomes, effectiveness which are collated and reported to surgeons and theatre managers.

Question 14: Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20?

ACN membership have posed the following impediments to shadow pricing:

- Definition of hospital size or location where services can receive fixed plus variable model.
- Services relocated from metropolitan to rural / remote for care closer to home where appropriate result in planning for care, transfer, increased nursing service provision. The funding needs to follow the patient from the date of referral.
- Perception of increased patient load / work requirements or change in operational demand without the ability to be renumerated.
- Education is required for management, clinicians and coders.

Question 15: Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

ACN strongly supports value-based health care and bundled payments funding models discussed by IHPA on pages 30 to 32 of their consultation paper. ACN agrees with IHPA that current Activity Based Funding models designed by IHPA do not provide incentives to maximise efficiency. ACN believes a focus on health care delivery should be on providing high value care to patients, with a patient-outcomes focused, value-based model of funding.

Question 16: IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

The Australian health system has significant gaps and inequalities, despite the health of many Australians being amongst the best in the world[12]. Aboriginal and Torres Strait Islander populations continue to have much lower life expectancy and higher rates of ill health than other Australians[13]. Nationally, consumer access to health care varies, especially for rural and remote populations[14]. There is rapid escalation in the number of people with chronic and complex health conditions (such as Diabetes, Respiratory, Renal disease, Rheumatoid Arthritis, Neurology – Parkinson's, MS), with their need for coordinated care not being addressed. The health and well-being of Australia's ageing population is very clearly not being nurtured consistently.

These pressures mean that achievement of best practice in health service is inconsistent. Best practice ensures that prevention and early intervention is provided through high-quality,

[12] Health Workforce Australia 2014: Australia's Future Health Workforce – Nurses Detailed. Retrieved from https://www.health.gov.au/internet/main/publishing.nsf/Content/34AA7E6FDB8C16AACA257D9500112F25/$File/AFHW%20-%20Nurses%20detailed%20report.pdf

[13] ibid

[14] ibid

community-based health services for all. Best practice ensures that people are hospitalised as a last resort. Hospital service should be safe and effective, with the patient at the centre of care.

In the Australian context, bundled payments should be explored for chronic conditions such as but not limited to heart failure where consumers can be supported by a nurse working within an interdisciplinary team environment in the primary healthcare environment. Nurse led models of care for chronic disease management would have an impact on disadvantaged communities such as rural and remote Australians.

Question 17: Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

ACN members agree that benchmarking is required, and increased reporting will follow. There should be documentation with plan of care to treat the HAC as part of the multidisciplinary team approach. It is everyone's business, all healthcare providers involved in the care of the patient to ensure HAC's via transparency are accounted for and reduced.

Question 18: What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

ACN members have provided the following suggestions for consideration:

- Patient discharges on oral antibiotics then readmitted for Intravenous antibiotics.
- Patients referred to GP's for follow up – no appointment acquired, nil availability of GP or medications due to community patient discharged too.
- Indigenous patients from remote areas discharge planning is required.
- Chronic Disease.
- Post-Operative patients admitted within 28 days of surgery.
- Mental Health patients discharged from the emergency department.
- Hospital in the Home Patients.
- Patients return to the emergency department within less than 48-72 hours WorkSafe-Community Nursing Services.