Australian College of Nursing

CONSULTATION PAPER ON THE AUSTRALIAN NATIONAL SUBACUTE AND NON-ACUTE PATIENT CLASSIFICATION VERSION 5.0

THE AUSTRALIAN COLLEGE OF NURSING (ACN) SUBMISSION TO THE INDEPENDENT HOSPITAL PRICING AUTHORITY (IHPA)

ACN General Comment

The Australian College of Nursing (ACN) would like to thank the Independent Hospital Pricing Authority (IHPA) for the opportunity to provide feedback on the **Draft Australian National Subacute and Non-Acute Patient Classification Version 5.0 (AN-SNAP V5).**

ACN supports the priorities outlined in the Draft: to investigate potential new variables based on clinical advice, and consideration of high volume and high average cost episodes, including patient frailty and comorbidities. As the pre-eminent and national leader of the nursing profession, ACN believes all nurses (Registered and Enrolled) have a critical role in promoting and supporting healthy ageing for all Australians. Nurses have the essential expertise in critical thinking, clinical assessment, clinical decision-making, care coordination and clinical and managerial leadership necessary to support older Australians to age well.

ACN released Position Statements on *The Role of the Nurse in the Assessment and Management of Multimorbidity* in October 2020 and on *The role of nurses in promoting healthy ageing* in March 2019. In these documents, ACN advocates for the nurse's role in supporting older Australians across a range of settings including community, general practice, residential care, acute care and correctional facilities. Nurses in these settings take the lead in supervising and mentoring unregulated staff. In many of these settings, the focus of health care is curative rather than preventive or considerate of health promotion limiting the opportunity for reablement and rehabilitation. More broadly, promoting health in partnership with the older person includes understanding the role of families and accessing appropriate health and social care support.

Like many developed countries, Australia has an ageing population. In 2017, approximately 3.8 million people (15% of Australia's total population) were aged 65 and over. This is expected to increase to 8.8 million older people in Australia (22% of the population) by 2057.[1] In Australia, it is estimated that around half of all people accessing primary health care services have two or more chronic conditions and a third of the population have three or more conditions.[2] The prevalence of multimorbidity is substantially higher among older adults[3,4,5] who have substantial and complex care needs.[6]

Older people are a diverse group whose care needs vary depending on the care environment and their presenting health issues. In the Position Statement, *The role of nurses in supporting older people to access quality, safe aged care*, ACN argued that care to older people must be personalised to meet the expressed needs and preferences of the individual, and in consultation with the individual or family where appropriate. Older people have the right to receive quality, evidence-based care consistent with their needs and to participate in their care decisions, undertake self-care and seek help early – all core components of safe, quality care.[7]

Nurses make up more than 50% of the health workforce with over 400,000 nurses working in Australia.[8] Nurses work across many sectors and are the most broadly dispersed geographically. Nurses are the best placed health professionals to prevent and manage chronic conditions and the development and management of multimorbidity. However, nurses have reported not feeling prepared or supported to assess and manage multimorbidity. A survey conducted by ACN's Chronic Disease Policy Chapter of 142 nurses across Australia found almost all nurses felt they needed additional education and training to improve the provision of care for people living with

multimorbidity (96%).[9] The majority of nurses (70%) believed current health care structures and systems did not provide them with sufficient support to effectively care for people living with multimorbidity and they had insufficient time to provide the level of care required.

Interviews with nurses on how the role of nurses can be developed to improve care for people living with multimorbidity found there were several enablers for nurses to be more effective in their role.[10] For instance, being empowered to take on a navigator role in order to coordinate and case manage the complexity of patient care; taking a more active role in the prevention and management of multimorbidity through nurse-led clinics and training other staff; and leading and contributing to research to better understand the needs of patients and families, including evaluation of the effectiveness of practice regarding multimorbidity approaches and interventions.[11]

Nurses are well positioned to deliver person-centred, cost-effective solutions to tackle the complex and growing issues related to multimorbidity. As such, ACN advocates for additional education and training, resources to support effective practice and opportunities for leadership for nurses in the prevention and management of multimorbidity.

ACN responses to consultation questions

Question 1: Does the proposed fifth version reflect contemporary clinical practice and terminology?

ACN members believe the AN-SNAP V5 reflects contemporary clinical practice and terminology that provides cost prediction for care episodes. The volume of care provision to match costs is important for service planning and ABF or block-funded service provision. Resource use can be more clearly explained in the AN-SNAP V5.

Question 2: Do you support IHPA's proposed approach to use the Frailty Risk Score calculated from ICD-10-AM codes as proxy markers of frailty? If not, why not? (pp. 9-15)

ACN members support the use of the Frailty Risk Score calculated from ICD-10-AM codes as proxy markers of frailty. As Australia's population ages, this tool will be a sound predictor to identify those at greatest risk of adverse outcomes. Hospital admission is often associated with an increased risk of harm and acts as a stressor to older patients whom already have complex conditions. This is useful for post-operative health care consumers so a risk-based approach to care can be provided to prevent adverse outcomes. This promotes quality care and a base for auditing care and care outcomes in acute care settings which can commence prior to admission.

Question 3: If the Frailty Risk Score is adopted for AN-SNAP V5, do you support IHPA's proposed approach to exclude less defined and redundant codes from the score's calculation? If not, why not?

Yes, ACN believes codes need to be defined to have meaning for coding, volume and costings, resource and data explanation.

Question 4: For future work (i.e. beyond AN-SNAP V5), do you prefer any particular prospective frailty instrument being prioritised by IHPA for further investigation (including potentially being proposed for the admitted subacute and non-acute hospital care national best endeavours data set)? If so, why? Examples of the type of instruments include but are not limited to the Rockwood Clinical Frailty Scale; and the Australian National Aged Care Classification (AN-ACC) assessment tool.

No, ACN does not have a preference for other instruments, as long as the instrument is evidence-based, up-to-date, able to be applied to the admitted subacute and non-acute hospital setting and any required training is provided.

Question 5: Do you support IHPA's proposal to establish a new impairment type group Orthopaedic conditions, replacement for knee, hip and shoulder replacement activity? (pp. 16-20)

Yes, ACN members support IHPA's proposal as orthopaedic conditions are more prevalent with the older age group of health care consumers and will only increase with Australia's ageing population. This represents a majority of the orthopaedic public waitlist categories 2 and 3.

Question 6: Do you support a measure of frailty being introduced into the classification for adult admitted rehabilitation care, in principle? If so, do you have an approach you recommend? (pp. 21-23)

Yes, ACN has addressed this in response to Question 2. Any measure of frailty must be evidence-based, current, able to cover a range of service modalities and include provision for any required training.

Question 7: Do you support IHPA continuing to explore the Functional Independence Measure for children (WeeFIMTM) as a potential variable within the paediatric rehabilitation classes? If not, why not?

Yes, ACN members believe this is important to ensure the full spectrum of health care providers is covered to ensure quality care is provided and governance procedures are maintained.

Question 8: Do you have any other suggestions for future work to refine the classification of adult or paediatric admitted rehabilitation care such as: care cost drivers which could be further investigated; and/or data items to consider for national collection?

ACN has no other comment on this matter.

Question 9: Do you have any suggestions for future work to refine the classification of adult or paediatric admitted palliative care such as: care cost drivers which could be further investigated; and/or data items to consider for national collection? (pp.24-25)

ACN members would like to see consideration of palliative care and end of life care where the patient was admitted, through to discharge to community-based palliative care. This has implications for cost drivers shifted to the community setting for resource splitting or diversion.

Question 10: Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the GEM care type? If not, why not? (pp. 25-26)

Yes, ACN members believe this proposal satisfies the goal of improving the function of a patient with multi-dimensional needs, associated with age-related medical conditions such as frailty and potential fractures.

Question 11: Do you have any suggestions for future work to refine the classification of GEM care such as: care cost drivers which could be further investigated; and/or data items to consider for national collection? (pp. 26-27)

ACN members would like to see consideration of care time and volume tailored to the needs of an individual health care consumer. Differences in individual care times are likely to be associated with differences in assessed function, cognition, behaviour and health status. This is taken into consideration with admission coding criteria, though comorbidities impact on care.

Question 12: Do you support IHPA's proposal to adopt the HoNOS 65+ total score to split short stay overnight episodes in the Psychogeriatric care type? (pp. 27-28)

ACN members believe this proposal is simpler for coding, not just based on length of stay, but also when taking into account other factors.

Question 13: Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the non-acute care type? If not, why not? (pp. 28-29)

Yes, ACN believes this has been addressed in above responses.

Question 14: Do you have any suggestions for future work to refine the classification of non-acute care such as: care cost drivers which could be further investigated; and/or data items to consider for national collection? (p. 30)

ACN members suggest further consideration of maintenance care. The clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. The patient may require care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting, for example at home, or in a residential aged care facility (RACF), by a relative or carer, that is unavailable in the short term. If a care facility is unavailable the aged care consumer is forced to wait for an RACF bed within a health care facility. Disability care within a health care facility increases the length of stay and time to care compared with a non-disabled consumer.

Question 15: Do you have any other comments about the Draft Australian National Subacute and Non-Acute Patient Classification Version 5.0?

No further comments at this time.

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[1] Australian Institute of Health and Welfare. Older Australia at a glance. Web report last updated 10th September 2018. Cat. no: AGE 87 Canberra: AIHW; 2018. https://www.aihw.gov.au/reports/ older-people/older-australia-at-a-glance/contents/summary

[2] Harrison, C., Henderson, J., Miller, G., & Britt, H. (2017). The prevalence of diagnosed chronic conditions and multimorbidity in Australia: A method for estimating population prevalence from general practice patient encounter data. PLoS One, 12(3), e0172935.

[3] Nguyen, H., Manolova, G., Daskalopoulou, C., Vitoratou, S., Prince, M., & Prina, A. M. (2019). Prevalence of multimorbidity in community settings: A systematic review and metaanalysis of observational studies. Journal of comorbidity, 9, 2235042X19870934.

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[5] Stanley, J., Semper, K., Millar, E., & Sarfati, D. (2018). Epidemiology of multimorbidity in New Zealand: a cross-sectional study using national-level hospital and pharmaceutical data. BMJ open, 8(5).

[6] Backman, C., Stacey, D., Crick, M., Cho-Young, D., & Marck, P. B. (2018). Use of participatory visual narrative methods to explore older adults' experiences of managing multiple chronic conditions during care transitions. BMC health services research, 18(1), 482.

[7]Australian College of Nursing (ACN). 2020. The role of nurses in supporting older people to access quality, safe aged care. ACN. Canberra. https://www.acn.edu.au/wp-content/uploads/position-statement-role-of-nurses-in-supporting-older-people.pdf

[8] Australian Institute of Health and Welfare. (2020). Health workforce. AIHW. Retrieved from https://www.aihw.gov.au/reports/ australias-health/health-workforce

[9] Australian College of Nursing (ACN). 2020. The Role of the Nurse in the Assessment and Management of Multimorbidity. ACN. Canberra. https://www.acn.edu.au/wp-content/uploads/position-statement-role-nurse-assessment-management-multimorbidity.pdf

[10] Ibid.

[11] Ibid.