Queensland Nurses & Midwives' Union

Submission to Independent Hospital Pricing Authority

Pricing Framework for Australian Public Hospital Services 2018-19

August, 2017

106 Victoria St, West End Q 4101
GPO Box 1289, Brisbane Q 4001
(07) 3840 1444
(07) 3844 9387
qnmu@qnmu.org.au
www.qnmu.org.au

submission

Introduction

The Queensland Nurses and Midwives' Union (QNMU) thanks the Independent Hospital Pricing Authority (IHPA) for the opportunity to provide feedback on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19*.

Nursing and midwifery is the largest occupational group in Queensland Health and one of the largest across the Queensland government. The QNMU is the principal health union in Queensland covering all categories of workers that make up the nursing workforce including registered nurses (RN), registered midwives (RM), enrolled nurses (EN) and assistants in nursing (AIN) who are employed in the public, private and not-for-profit health sectors including aged care.

Our more than 56,000 members work across a variety of settings from single person operations to large health and non-health institutions, and in a full range of classifications from entry level trainees to senior management. The vast majority of nurses in Queensland are members of the QNMU.

The QNMU's submission responds to a subset of the consultation questions.

What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?

The QNMU recommends that IHPA align the new version of the Australian Refined Diagnosis Related Groups (AR-DRG) classification system with evidence-based models of care to direct and reinforce the implementation of best practice in the health sector. This should include and acknowledge the work performed by nurses and midwives. Improvements to the AR-DRG should be clinically coherent and the clinical services provided should be conducted within a profession's scope of practice by individuals who are educated, competent and authorised to perform these tasks.

In our view, the current Weighted Activity Units (WAU) do not adequately capture nursing and midwifery work and need to be urgently reviewed to ensure they do. We recommend IHPA undertakes a fundamental review of its methodology in relation to nursing and midwifery that takes into account current evidence and practice.

A focus on consumer outcomes, statistics and minimum datasets as per national and international standards is highly recommended to support the continual improvement and delivery of safe, high quality healthcare.

Consultation with key stakeholders such as consumer groups, clinicians, professional bodies and health services is deemed essential to ensure the applicability, legitimacy and appropriateness of the services included in the development of the new AR-DRG.

Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?

The QNMU supports the phasing out of the older versions of the AR-DRG. The new edition should continue to reflect clinical practice and use of hospital services, including the role of nurses and midwives. Evidence shows appropriate staffing of nurses and midwives increases the quality of care for patients and is a cost-effective patient-safety intervention (Twigg, Gelder & Myers, 2015; Twigg, et al., 2013).

What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

The QNMU recommends the transition to the new AR-DRG align with previous change management processes used by IHPA. There should be enough lead time for changes to technology and to permit stakeholders the ability to undertake training, education and support. Equally, the provision of quality health services by nurses and midwives should not be compromised by the transition.

Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18?

The QNMU supports the proposal to shadow price non-admitted multidisciplinary case conferences. The IHPA should work with jurisdictions including nurses and midwives to ensure all clinical care types are accommodated.

Do you support investigation of the creation of multiple classes in the classification for home ventilation?

The QNMU welcomes the investigation into multiple classifications for home ventilation. A high level of care is required and should only be undertaken by those professionals who possess the necessary qualifications, skills and authority to provide this treatment and support.

What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

The QNMU highly recommends IHPA consider:

- Consumer needs be the primary principle and rely on evidence-based models of care;
- Consultation and inclusion of all key stakeholders, including nurses and midwives;
- Transparency to ensure quality in care and cost;
- Inclusion of indirect care with diagnoses. This indirect care is performed away from the patient, often by nurses. This supports the overall effectiveness of direct care interventions (Kakushi & Evora, 2014);
- Allowance for variability in treatment plans to cover comorbidities and complexities;
- Consideration of which clinician is best to provide the service;
- The use of the business planning framework (BPF) - the industrially mandated tool in Queensland Health to determine nursing and midwifery workforce requirements;
- The inclusion of classifications for teaching, training and research for nursing and midwifery undergraduates and postgraduates.

Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?

The QNMU supports IHPA in continuing to develop an approach to price for mental health phase of care based on collected data and evidence. The pricing model should consider the complexity and risks of mental health care and include acute and rehabilitation and/or recovery. Payments should be linked to a patient to cover both inpatient and outpatient services. Input from across jurisdictions should be incorporated to distinguish phases of care.

What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?

The QNMU believes the national efficient price (NEP) should include the costs associated with nurses and midwives delivering safe care. Establishing and maintaining safe workloads includes minimum nurse/midwife-to-patient ratios and those health facilities that have these ratios should not be penalised. Current research has proven safe nurse/midwife-to-patient ratios in conjunction with a higher proportion of nurses and better practice environments improves patient satisfaction, lowers mortality rates, decreases readmission rates and reduces adverse events such as infections, pressure injuries and postoperative complications (Twigg, et al., 2013; Lankshear, Sheldon, & Maynard, 2005 & McHugh, Berez, & Small, 2013).

The QNMU also identifies palliative care within the aged care sector to be an area for consideration. With Australia's ageing population, the aged care sector will continue to grow. The aged care sector provides older Australians with a range of different services and these services should include palliative care. It is essential to ensure there is sufficient funding in the public sector to support the provision of in-reach services for palliative care to aged care facilities, thereby reducing the need for residents to access inpatient services. Consultation with the aged care sector is essential.

What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

Social determinants of health are patient-based factors. These health-related social needs are the economic and social conditions that impact health, and include the environment in which people are born, grow, live, work, and age. They generally refer to factors that affect health outside of the health care system and that are beyond an individual's control (Deloitte Center for Health Solutions, 2017). This includes:

- Living in rural and remote communities;
- Indigenous patients and the need to identify and understand their cultural and linguistic differences. Communication strategies will assist to engage with this population and include using medical interpreters and use of diagrams (Amery, 2017);
- Improving services specific for people from culturally and linguistically diverse backgrounds (CALD) such as interpreter services (Department of Social Service, 2015);
- Transportation to medical appointments including affordable, reliable transport and parking whether patients need to travel to city centres for treatment.

The allowance for flexibility in treatment plans to cover comorbidities and patient complexity is a patient-based factor that should also be considered.

Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?

The QNMU supports the transfer of public hospital services between activity based funding (ABF) and block funded hospitals, without financial penalty. This will increase access to services for rural communities. The transfer of services should be transparent. The QNMU recommends a consistent strategy and a phased approach with the service provider given

sufficient notice for planning and preparing. Data capture and publication should also be part of this process (KPMG, 2017).

The QNMU advocates these transfers should only be provided within a profession's scope of practice by a professional who is educated, competent and authorised and with safe staffing levels. For example if a maternity service is transferred to a rural health service, this services should practice midwife-led continuity models of care.

The QNMU supports the continuing investigation into whether there is a financial impact from transferring services from ABF to block funded hospitals and the methodology used for this calculation.

Do you support IHPA's proposal to continue to block fund residential mental health care in future years?

QNMU supports the proposal providing it follows evidence-based models of care and until data is captured to support otherwise.

Do you support the proposed bundled pricing model for maternity care?

The QNMU supports the bundled pricing model for maternity care. We continue to strongly support that the advisory group comes to a decision regarding newborn care within the scope of the bundling pricing approach. There is a significant increase in normal/well baby care such as assisted feeding and routine observations and tests related to clinical guidelines. The increased acuity of mothers results in increased demand on care requirements/options for an unqualified baby. The QNMU contends the exclusion of admitted care for newborns should remain.

Do you agree with IHPA's assessment of the preconditions to bundled pricing?

The QNMU agrees with IHPA's assessment.

Do you support investigation of whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets?

The QNMU supports the bundled Individual Healthcare Identifier.

What issues should IHPA consider when examining innovative funding model proposals from jurisdictions?

The QNMU suggests a number of issues for IHPA to consider. Innovative funding models:

- Should be based on meaningful and up-to-data data. Patient data must be safeguarded which includes the communication of healthcare data to relevant stakeholders (KPMG, 2017);
- Be an evidence-based approach to guarantee there is real benefit to the patient for the investment of resources (Queensland Health, 2016);
- Should include all relevant jurisdictions in the process;
- Should incentivise for quality and best-practice outcomes. (PricewaterhouseCoopers, 2016).

Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?

The QNMU supports new models of value-based care if they are evidence-based and focus on health maintenance and improvement (World Economic Forum & Boston Consulting Group, 2017). Issues for consideration include:

- A model for the management of chronic and complex conditions including comorbidities with integrated and coordinated care. There are, however, risks with this model which include under provision of services, and cherry picking of patients to avoid those more complex patients. This could prevent access for those patients with high needs and reduce equity of care so this model should be evidence-based (Australian Healthcare & Hospitals Association, 2015);
- A palliative care model where patients are seen in their home. This home visiting model can be through a home-visit service provided by nurses and/or include telehealth (Chen, et al. 2015 & Queensland Health, 2016). This palliative care model is shown to decrease hospital admission rate and average total hospital days (Chen, et al. 2015);
- Rural and remote communities should be included to continue to reduce health inequalities. Value-based care models should continue to investigate whether fly in/ fly out services are the most appropriate healthcare approach (Wakerman, Curry & McEldowney, 2012);
- Whether public hospitals can work more directly with the Primary Health Networks. The overlap between public health and primary care is evident and benefits can be seen for both health systems to collaborate (Booth, et al., 2016).

Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?

The QNMU takes the view that the proposed risk adjustment model for hospital acquired complications (HACs) is a punitive rather than an incentive approach. It is acknowledged that modern health services may inflict preventable harm on patients. However, caution must be practiced to ensure a culture of openness and fairness rather than one of blame. Staff must feel secure so if errors are made, under-reporting does not occur due to fear of punishment (Sujan & Furniss, 2015).

The QNMU recognises a need to consider risk adjustment models for HACs. Minimum nurse/midwife-to-patient ratios and endorsed skill mix levels are an economically sound method to save lives and improve patient outcomes. National and international studies have irrefutably proven the number, skill mix and practice environment of nurses/midwives directly affects the safety and quality performance of health services. Health services with a higher percentage of registered nurses and increased nursing hours per patient will have lower patient mortality, reduced length of stay, improved quality of life and less adverse events such as failure to rescue, pressure injuries and infections. (Aiken et al., 2014; Tubs-Cooley et al., 2013; Lankshear et al., 2005; McHugh et al., 2013). These studies indicate:

- Every one patient added to a nurse's workload is associated with a 7% increase in deaths after common surgery (Aiken, et al., 2014);
- Every 10% increase in bachelor-educated nurses is associated with a 7% lower mortality (Aiken, et al. 2014);
- Every one patient added to a nurse's workload increased a medically admitted child's odds of readmission within 15-30 days by 11% and a surgically admitted child's likelihood of readmission by 48% (Tubbs-Cooley et al., 2013).

Further, the QNMU has concerns that from 1 July 201, sentinel events are not funded. This l may potentially cause an undue bias against hospitals where these situations are more likely to occur. For example whilst maternal death is a tragic and at times preventable event, some hospitals are far more likely to experience this event than others (i.e. tertiary hospitals, particularly those specialising in women's services). Another example is that inpatient suicide again is more likely to occur in facilities where there is a mental health inpatient unit. There are some sentinel events which are most certainly related to human or system error – such as a procedure on the wrong limb or person causing permanent damage or death, discharge of an infant with the wrong parents. However sentinel events such as maternal death and inpatient suicide may occur despite the best efforts of the hospital team.

Reduction of funding – for any reason – will potentially have a negative impact on care provision as facilities try to deal with reduced budgets. If a facility is already experiencing one, or more, sentinel events, reduction of funding is not likely to improve outcomes.

Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

The QNMU agrees that third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment. However, IHPA should continue to collect datasets for these events in order to develop a reliable risk adjustments model to revisit in the future.

What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

The QNMU asks IHPA to consider midwife-led continuity models as one midwifery model to reduce readmissions. These are based on woman-centred care and are associated with a primary midwife who provides care from early in pregnancy, throughout pregnancy labour and birth, to six weeks post birth. The primary midwife coordinates care for the woman, facilitates access to care that is more complex and other carers according to her needs.

There are several benefits to midwife-led continuity of care for women including a significant reduction in interventions such as epidurals, episiotomies and instrumental births as well as a reduced likelihood of preterm birth or losing their baby before 24 weeks gestation.

Numerous studies have established there are no identified adverse effects of midwife-led continuity of care when compared with models of medical-led care and shared care (Sandall et al., 2013). Further, readmission rates are reduced when midwifery models of care are used (Coyne, et al. 2016).

Another nursing model is the nurse navigator. The nurse navigator is patient-centred and has many roles including navigating the health system for the patient. By directing patients to existing programmes and community supports, it is posited that patient's will experience less fragmentation of health services, length of hospital stays will be reduced along with readmission rates (McMurray & Cooper, 2016). Nurse navigators oversee the clinical pathway and work with other health professionals to effectively manage length of stay which equates to financial savings for the hospital (Seldon & McDonough, 2016).

Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?

The QNMU agrees in principle provided it is evidence-based and the Pricing Guidelines remain transparent.

References

Aiken, L., Sloane, D., Bruynell, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kozka, E., Lesaffre, E., McHugh, M., Moreno-Casbas, M., Scwendimann, A., Scott, P., Tishelman, X., Acterberg, T. & Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: a retrospective observational study. *Lancet*, 383(9931), 1824 -1830.

Amery, R. (2017). Recognising the communication gap in Indigenous health care. *Medical Journal of Australia,* 207(1), 13-15.

Australian Healthcare & Hospitals Association. (2015). *Bundled payments: their role in Australian primary health care.* Retrieved from https://ahha.asn.au/sites/default/files/docs/policy-issue/bundled_payments_role_in_australian_primary_health_care_0.pdf

Booth, M., Hill, G., Moore, M., Dalla, D., Moore, M. & Messenger, A. (2016). The new Australian Primary Health Networks: how will they integrate public health and primary care? Public Health Research & Practice, 26(1), e2611603

Chen, C., Thorsteinsdottir, B., Cha, S., Hanson, G., Peterson, S., Rahman, P., Naessens, J. & Takahashi, P. (2015). Health care outcomes and advance care planning in older adults who receive home-based palliative care: A pilot cohort study. *Journal of Palliative Care*, 18(1), 38-44.

Coyne, I., Comiskey, C., Lalor, J., Higgins, A., Elliott, N. & Begley, C. (2016). An exploration of clinical practice in sites with and without clinical nurse or midwife specialists or advanced nurse practitioners, in Ireland. *BMC Health Services Research*, 16.

Deloitte Center for Health Solutions. (2017). *Social determinants of health: How are hospitals and health systems investing in and addressing social needs?* Retrieved from

https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/addressing-social-determinants-of-health-hospitals-survey.html

Department of Social Services. (2015). *Review of Australian Research on Older People from Culturally and Linguistically Diverse Backgrounds*. Retrieved from http://fecca.org.au/wp-content/uploads/2015/06/Review-of-Australian-Research-on-Older-People-from-Culturally-and-Linguistically-Diverse-Backgrounds-March-20151.pdf

Kakushi, L. & Evora, Y. (2014). Direct and indirect nursing care time in an intensive care unit. *Revista Latino-Americana De Enfermagem,* 22(1), 150-157.

KPMG. (2017). *Through the looking glass: A practical path to improving healthcare through transparency*. Retrieved from http://www.kpmg-institutes.com/content/dam/kpmg/healthcarelifesciencesinstitute/pdf/2017/through-looking-glass.pdf

Lankshear, A., Sheldon, R. & Maynard, A. (2005). Nurse staffing and healthcare outcomes: a systematic review of the international research evidence. *Advances in Nursing Science*, 25(2), 163-174.

McHugh, M., Berez, J. & Small, D. (2013). Hospitals with higher nurse staffing had lower odds of readmissions penalties than hospitals with lower staffing. *Health Affairs,* 32(10), 1740-1747.

McMurray, A. & Cooper, H. (2016). The nurse navigator: an evolving model of care. *Collegian.*

PricewaterhouseCoopers. (2016). *Healthcare reform. Why the stars are finally aligning*. Retrieved from https://www.pwc.com.au/publications/pdf/health-healthcarereform-report.pdf

Queensland Health. (2016). *Value-based healthcare – shifting from volume to value*. Meeting report. Retrieved from https://www.health.qld.gov.au/clinical-practice/engagement/clinical-senate?a=164313

Sandall J., Soltani H., Gates S., Shennan A., & Devane D. (2013). Midwife-led continuity models of care for childbearing women. *Cochrane Database of Systematic Reviews*, 8.

Seldon, L. & McDonough, K. (2016). Evaluation of a hospital-based pneumonia nurse navigator program. *The Journal of Nursing Administration,* 46(12), 654-661.

Sujan, M. & Furniss, D. (2015). Organisational reporting and learning systems: innovating inside and outside of the box. *Clinical Risk,* 21(1), 7-12.

Tubbs-Cooley, H., Cimiotti, J., Silber, J., Sloane, D. & Aiken, L. (2013). An observational study of nurse staffing ratios and hospital readmission among children admitted for common conditions. *BMJ Quality and Safety*, 0, 1-8.

Twigg, D., Geelhoed, E. Bremner, A. & Duffield, C. (2013). The economic benefits of increased levels of nursing care in the hospital setting. *Journal of Advanced Nursing*, 69(10), 2253-5561.

Twigg, D., Gelder, L. & Myers, H. (2015). The impact of understaffed shifts on nurse-sensitive outcomes. *Journal of Advanced Nursing*, 71(7), 1564-1572.

Wakerman, J., Curry, R. & McEldowney, R. (2012). Fly in/fly out health services: the panacea or the problem? *Rural and Remote Health*, 12, 2268.

World Economic Forum & Boston Consulting Group. (2017). *Value in healthcare: laying the foundation for health system transformation*. Retrieved from http://www3.weforum.org/docs/WEF_Insight_Report_Value_Healthcare_Laying_Foundation.pdf