Australasian College
for Emergency Medicine

ACEM Response to IHPA Consultation 2023-24

1. Context

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide feedback on the Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2023–24.

As the peak body for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand.

2. Section 5.3 Emergency Care

2.1 Australian Emergency Care Classification

The introduction of the Australian Emergency Care Classification (AECC) in the National Efficient Price Determination 2021-22 (NEP21) was a significant change, and ACEM looks forward to seeing further analysis of the impacts of the classification.

As noted in our submission last year ACEM stands ready to support efforts to ensure that the AECC reflects the level of care provided to patients who present in emergency departments, and who are admitted to hospital but can't be sent to an inpatient ward due to access block. These patients receive the equivalent of inpatient care while in the ED (anywhere from 8 hours to several days) and then are subsequently discharged from ED, however under the AECC, results in a significant reduction in cost calculation and funding allocations. This needs to be monitored closely to ensure the full scope of work is being captured within the system.

In the context of an emergency department, working with undifferentiated patients, activity-based funding must reflect the complexity of patient presentations. This includes the complex thought processes and investigations that may be required (whether the result is positive or negative for a condition), and the type of workforce that is required to safely conduct an accurate assessment. As such, final diagnosis does not always reflect complexity of the patient presentation (or the steps required to get the diagnosis).

The IHPA should consider the need to collect and track the presenting problem and mapping terms across systems, as these drive a lot of the investigation costs rather than the ED final diagnoses which, for example, may end up being chest pain for a person who is investigated for an aortic aneurysm.

2.2 Access block

Access block is the biggest issue facing EDs across Australia. Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from transferring to a ward or another appropriate health facility for more than eight hours because of a lack of inpatient bed capacity. Access blocked patients also include those who were planned for an admission but were discharged from the ED without reaching an inpatient bed, transferred to another hospital for admission, or who died in the ED while awaiting admission.

Patients that attend an ED experiencing access block have an 10% greater risk of dying within a week than patients that attend an ED without access block. Data from the Australian Institute of Health and

Welfare indicates that between 2014-15 and 2018-19 the ratio of public hospital beds to population was stable at between 2.5 to 2.6 beds per 1000 population, while presentations to EDs requiring hospital admission increased by 3.2% on average per year.

This creates situations where EDs are looking after patients for longer, which reduces the capacity of staff to meet the needs of other patients, due to lack of both time and available space. Access block is also the fundamental cause of ambulance ramping (the inability to offload patients from ambulances into appropriate bed spaces in ED). As a matter of urgency IHPA should track the ED costs for prolonged length of stay and ensure that pricing adequately reflects activity for these patients. Our research shows many ED staff can spend one third of their time looking after admitted patients who should have already been transferred to an inpatient ward.

3. Response to specific consultation questions

3.1 (2) Impact of COVID-19: Are there any specific considerations IHPA should take into account for assessing COVID-19 impacts on the 2020–21 data in the development of NEP23?

Many EDs in Australia experienced a decline in presentations during the first phase of pandemic. However, strict personal protective equipment (PPE) requirements, along with the need to stream COVID, suspected COVID and undifferentiated patients greatly increased the complexity of work for ED staff.

ED demand is returning to trend, however significant workforce shortages are impacting on the ability of EDs to manage these excessive workloads. Extreme caution is required in utilising COVID-19 affected time period (particularly March 2020 to January 2022) to project ED presentations in future years.

There are a range of public health and patient care factors that are likely to lead to increased ED presentations in coming years, including:

- the mental health impacts of the pandemic,
- increases in alcohol and other drug use during the pandemic, which may be sustained, and
- attempts to address the backlog in care for chronic conditions and elective surgery.

3.2 (6) Setting the National Efficient Price: Are there any adjustments IHPA should prioritise investigating to inform the development of NEP23?

ACEM welcomes the commitment as per Clause A47 of the Addendum to determine adjustments based on hospital type and size, hospital location and patient complexity. Poor quality access to primary care in regional and remote areas is an important driver of ED presentations in a way that is distinct from metropolitan areas.

3.3 (6) Setting the National Efficient Price: What cost input pressures that may have an impact on the national pricing model and are not included in the NHCDC should be considered in the development of NEP23?

Workforce shortages have the potential to have a significant impact on the cost of service delivery across the system. A lack of stable, permanent staffing drives inefficiencies in service delivery alongside the direct costs of an increased reliance on agency-based staffing.

3.4 (7) Setting the National Efficient Cost: What cost pressures for regional or remote hospitals should be considered in the development of NEC23?

- Attracting workforce
- Retaining workforce
- Cost of living pressures
- Lack of access to adequate primary care

3.5 (8) Future funding models: How is virtual care delivery captured in information systems and data collections?

The use of telehealth in emergency medicine settings is an emerging and rapidly evolving area of clinical practice in Australia. The College notes that there is an increasing range of service providers delivering various forms of telehealth emergency care.

ACEM acknowledges that the expansion of some forms of telehealth services have been shown to be positive for increasing patient access to healthcare in specific settings. The College supports measures that improve patient access and provide high quality patient-centred care. ACEM supports innovation, however the use of telehealth in emergency medicine is in its formative stages, and as such there has been limited research and evaluation to establish a strong evidence-base for clinical practice in the context of emergency care.

The College supports the investigation of virtual care funding for emergency departments in order to recognise the value that this is has the potential to provide to the community, but also to recognise that it utilises resources that are being drawn from physical service delivery, that need to be replaced.

The College is concerned about the fragmentation of data systems that is currently being observed making it difficult to understand and evaluate the impact of these services. An important distinction is the provision of telehealth by emergency physicians while integrated into their hospital's systems. This allows for data collection to occur in close to normal circumstances and supports continuity of care. Where telehealth service provision is contracted in from a private entity, risk of gaps in data collection, communication, knowledge of the local context and patient pathways are heightened.

The College notes that the paper states that 'Telehealth video consultations in emergency departments provide an equivalent to face-to-face consultation'. The College would like to further understand the basis for this assertion and whether it is referring to clinician-to-clinician consultations, or clinician-to-patient consultations. It is ACEM's position that advice given by telephone/video does not constitute a comprehensive assessment.

The provision of advice between clinicians is a well-established practice and the newer models of telehealth extend this in new ways which have the potential to improve patient care and system efficiency. The key will be to avoid high-cost, low-value care that acts merely as an additional barrier to care for people who need to attend an ED. This work should be appropriately priced to ensure that public EDs are not taking on additional responsibility without the appropriate resourcing to do so safely.

The College is cautious about clinician-to-patient telehealth in the context of emergency care. A full assessment includes a physical examination and bedside tests, which are not available through telemedicine. An emergency department comprises an interdisciplinary workforce with access to extensive medical equipment and pathways to care with other specialities. In this context, is unclear how a telehealth consultation could be considered as an equivalent to a physical presentation to an ED.

There is also risk emerging that the provision of emergency telehealth services are drawing additional workforce from the physical ED and creating gaps. This risks creating a viscous cycle, whereby physical EDs become more understaffed, leading to more telehealth utilisation as a coping mechanism, drawing even more staff out of the ED, and so on.

Equitable access to emergency healthcare for all people is a cornerstone of emergency medicine. There are ethical concerns that people who are already marginalised, such as people with poor literacy, mental health issues, homelessness, English as a second language, no or limited access to technology may not be able to access telehealth services and thereby worsen the disadvantage.

3.6 (8) Future funding models: IHPA is proposing to investigate the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and Emergency service care National Best Endeavours Data Set for 2023–24. Are there any other examples of innovative models of care and services related to virtual care that IHPA should also consider investigating?

Regarding telehealth consultations, ACEM considers that:

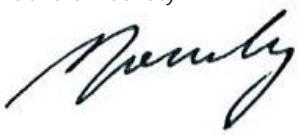
- Telehealth has the potential to be an important complement, but not a replacement, for locally and regionally provided comprehensive health care.
- Advice given by telephone/video does not constitute a comprehensive assessment.
- The expansion of telehealth services is not an appropriate solution to address health care workforce capacity and maldistribution.
- The utilisation of telehealth must not have the unintended consequence of creating additional barriers to access to emergency medical care for vulnerable patient groups.
- The utilisation of telehealth services must ensure that definitive care is not delayed, and that costs to the system are not being incurred for low value care that would not have otherwise been provided.
- The implementation of models of care that change the well-established and validated way in which emergency care is delivered requires extensive consultation with all relevant stakeholders, including emergency medicine physicians, and particularly from across the public health system before they can be operationalised and scaled.
- Targeted independent research and evaluation that builds an evidence base is required to support the use of telehealth in emergency medicine.
- The practitioner must have regard for the local context, including but not limited to, knowledge of the local population, availability of services, and patient pathways.

It is essential that the College is involved in the IHPA investigations of the inclusion of emergency department telehealth video consultations in the NAPEDC NMDS and the Emergency Service are National Best Endeavours Data Set for 2023-24.

4. Contact details

For more information or to clarify any aspect of this submission, please contact James Gray, Manager, Policy and Advocacy at james.gray@acem.org.au or on 0427 054 408.

Yours sincerely



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