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ACC Community Nursing Contract

ACC have made some changes to their Community Nursing Services contract variation March 2010 which apply to all providers (DHB, NGO) of this service. These changes are having a major impact on the quality of care given to New Zealanders who suffer a personal injury requiring referral to a community nursing service, predominantly for wound management.

This paper sets out the rationale for the College of Nurse's concern about these changes.

The potential consequences to the changes in the ACC community Nursing Contract are:

- More wound infections and less wound healing, particularly in the old and fragile patient group, and the low socio economic group.
- Overloading of GP surgeries and DHB District Nursing Services with referrals for wound management. These services have variable resources and expertise
- Delayed wound assessment and management by nurses who have wound expertise and capacity to provide continuity of service
- Cost shifting in health as providers of the community nursing contract move ACC clients into the care of the DHB when requests for extension of treatment visits declined by ACC
- Potential for ACC (and DHBs) to end up with higher end costs in cases where cellulitis and other serious complications develop.
- Due to changes in the ACC community nursing contract related to eligibility and referral criteria there will be a shift in referral behaviour that will potentially see an impact on the NGO sector. The NGO sector has built capacity and capability to integrate community services across home based support contracts and sustaining nursing in this sector is critical to ensure safety and capacity for MOH strategies such as aging in place.

Changes to the ACC community nursing contract have been driven by ACC to manage a number of key issues that have a financial impact on the funder but also recognise that there is cost shifting in primary and secondary care. The eligibility for referral has been tightened, specifically for referred claimants who, "are physically unable to access clinic based services." As a "referred in service" there is increased onus on the referrer to follow the contract specification which has had an impact on referral times and start of treatment to claimants.

A key issue is the inability of many claimants (specifically the frail elderly) to pay the co-payment for the GP visits and ongoing treatment. Prior to the variation change it was acceptable for the community provider to complete an ACC 45 on the GP's advice and commence treatments without the claimant requiring to go to their GP immediately. However ACC have deemed this as "self referral" which contravenes a "referred into" service contract. A consequence of this is that the people with injuries who are delaying going to their GP's are the most vulnerable people in communities e.g. the elderly and frail and the low socio economic groups. Additionally, GPs often cannot give an appointment for 48 hours as a minor injury is not deemed as an emergency. However if untreated for this duration, some injuries can become infected or sustain tissue death.

The original contract:

History: This contract was developed as a result of a gap being identified in claimant access to Community Nursing Services. The aim of Community Nursing Services is "to provide treatment to claimants within the community in either their home of workplace." P1

The objective is "to provide claimants with timely access to quality nursing treatment services with the purpose of restoring the claimant's health to the maximum extent practicable." P1 (*this is also in the new schedule*)

Service philosophy: The vendor will provide, at no cost to the claimants, treatment which is necessary, appropriate, timely and demonstrates the use of best practice. P1

Service requirements: Providers will deliver Service described in clause 7:1 -----which are within their scope of practice and are appropriate to the Claimant's identified needs (without limitation) P6

Service specific quality requirements:

Competency: "ACC is committed to purchasing services from Vendors who can provide and demonstrate a quality service." P7

All above come from Agreement for services between ACC and (whichever provider) for the Community Nursing Service, Version 2, which was rolled over from March 09-March 2010 when the revised conditions were introduced for all providers operating under this contract.

Under the original contract, once the claim was approved, providers had 12 "short term" visits over maximum of 9 weeks, they then applied for extension of visits if wounds not healed and this was invariably granted – usually at 9 visits, and most wounds healed in this time, but the majority actually healed in the initial 12. If applying for further extensions, ACC usually requested an independent nursing assessment to see if client should remain on ACC or whether co-morbidities were contributing to non-healing.

The ACC service schedule operational guidelines (April 2010) lays out the contract revisions. In relation to patients who have difficulty with part payment 2 examples are provided.

Contract revisions:

"The service was planned and implemented to specifically provide short term treatment for trauma/injury for people who are physically unable to access services at a clinic. Services are to be provided in a community setting – namely the client's home or a place as requested by ACC.

This does not include workplaces that have a nurse on the premises.

It does not include clients receiving long term care in a hospital or care in a residential institution. Clients living independently in these facilities are covered." All on P1.

There is a list of quality outcomes of particular relevance. They are:

- Collaboration
- Client satisfaction
- Service providers have proven competence levels to match the client's needs and there is documented evidence of performance monitoring.

In terms of impact on clients from the changes, 2 examples are given below:

Example 1: A solo Maori dad with 3 children, one under school age and of very low socio-economic means, being treated for a burn by the Community services. If extensions of visits cease - time, costs related to petrol and costs related to part payment mean he may not attend the GP – likely to end up with cellulitis and/or hypertrophic scarring.

Example 2: A 75 year old lady who was informed by the service that after our next visit she would have to return to her GP for treatment, even though another couple of visits would probably have seen her heal. She stated she had been paying $20 a GP visit before referral to us, and she would not return to them as she could not afford it. Hopefully her wound will heal with self care now, or it may break down again.

This also raises the issue of NGOs referring to District Nursing services. For patients with co-morbidities relating to non healing this has always been done, but under the new contract, complaints are made about "dumping" patients and that DHBs cannot fund these clients, hence they are referred back to GPs. This does not encourage the collaboration with other health professionals on which ACC is so keen.

Consumables:

One of the changes from the old contract is that if nurses want to use a product that costs more than $20 under the short term contract they have to seek approval from ACC. This does not endorse any of ACC statements around competencies, best practice or quality care. ACC have recognised that it is unrealistic for judgements to be made prior to the claimant's injury being assessed regarding product choice. They have signalled they will look at being more flexible with this. There are probably about 4-5 consumables in this price group, but when they are needed they should be applied.

A further change is that the providers can no longer fill out an ACC 45 to register a claim. This is based on the fact that clients are supposed to have a choice of provider, and so providers cannot refer to their own service. It would be interesting to conduct an audit of ED departments/clinics and GPs to see how many offer their patients choices. This was never a large part of the business, but there are specific clients where not being able to do this causes major issues for them. Additionally clients cannot self refer to us anymore – surely this IS the client choice, they have developed a relationship and trust a particular provider , and this is being eroded when that provider now must refuse to visit. . ACC require any provider who starts treatments as a treatment provider without being referred into the ACC community nursing contract to claim under the "treatment regulations."

Example 1: A client phoned us to say she had just fallen and had a new injury, could we attend? This was client choice – we are already treating her for another injury. In line with the new contract we told her she had to see her GP – she could not get an appointment for 48 hours by which time the flap injury was non viable and will result in a wound at high risk of infection which will take longer to heal. ACC need to realise that unless a fall is life or

limb threatening, the reality nowadays is that patients will not get treated immediately by their GP as the community nursing services could. We could do this visit under "treatment regulations" which does not cover cost of consumables and travel and where the provider is an NGO this is a considerable cost if it happens frequently.

Example 2. A woman of 102 who lives in a rural district and frequently suffers small injuries in her home. The GP is happy for the nurse to visit and fill out the ACC 45, when needed. He does not have time to do this, and getting to the clinic would be a major undertaking for the client. This woman must now be at high risk of not receiving treatment at all, and at her age infection would have a major impact on morbidity and possibly mortality.

There is a separate issue around this which has been ongoing, and that is the suitability of GPs without specific expertise to treat some of the wounds. There are GP's who now recognise they do not have this knowledge, nor do they have the consumables in their surgeries, and many of them keep cheap (and in some instances) very outdated wound products. ACC funds GPs indefinitely to provide wound care – sometimes 6 months before they are referred to nursing services, yet as soon as they enter the Community Nursing services strict visit numbers are applied. For the whole of this time the clients pay a part payment which varies from GP to GP – this can be a major issue for some patients and indeed discourages attendance at the surgery. ACC need to review the number of visits to a GP, given that a wound is now deemed chronic if not healing in an orderly manner by the fourth week – this is widely accepted internationally within wound circles. The same quality standards should be applied to all health providers.

Example: Referral sent to us for a 12 year old boy who had sustained a deep knee laceration 3 weeks previously. Wound had not completely taken with suturing and mother was told to visit GP for daily (dry) dressings and encouraged to expose the wound to the air (which may have accounted for the wound infection which developed). On referral the 2 wounds were 2.5x1.5 cm and 2x1 cm, still into subcutaneous tissue with moderate exudate. We anticipate healing within 8-9 visits, but it took some time to discuss with the mother the rationale for dressings 2x a week and covering the wound. She admitted she was fed up with conflicting advice. For all her visits to the GP she was part charged. A 12 year old should have healed in a more timely and less complicated manner than this.

In terms of not visiting Rest Home clients, this was allowed in the past providing the GP had seen the patient. People living independently can be referred into the ACC community nursing contract, however many elderly cannot get to their GP and there is a delay in assessment and appropriate treatment for this vulnerable group.

There is variable resource and competency in rest homes regarding wound expertise and product knowledge in order to treat these clients effectively. They should be included under this community contract, otherwise they are receiving sub optimal care and again are the group most likely to develop complications requiring hospitalisation.

One final point; some District Nurse services are operating under DHB bulk funded or capped capacity contracts. By shifting previously ACC funded clients to the DHB funding pool there will be reduced overall service capacity in community nursing - negatively impacting length of hospital stay and district nurse's ability to contribute to acute demand management. This situation may also lead to a reduction in the employment of nurses in the community sector due to significant funding constraints; this is contrary to the current policy direction to move more services closer to the patient.

ACC community nursing contract review

ACC have completed a sector survey earlier this year to inform them regarding changes to community contacts for 2011. There is an intention to review all community home based contracts that require nursing and look at how best to contract for nursing in the community across ACC home based support contracts.

ACC have set up a stakeholder consultation group commencing June 14 2010 that has wide representation across the primary and secondary sector, including private providers and NGO providers. There are opportunities to make some significant change to the way services are delivered to claimants with personal injury in the community that will impact on population health outcomes. It will also gives nurses an opportunity to contribute and work differently across the health system to ensure people's needs are being meet in a timely and responsive manner.

The College appreciates the contribution of expert nurse clinicians to compiling this report.

Yours Sincerely

Professor Jenny Carryer

Executive Director