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Submission to the Independent Hospital Pricing Authority
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DEVELOPMENT OF THE AUSTRALIAN EMERGENCY CARE CLASSIFICATION (AECC)

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide comments to the Independent Hospital Pricing Authority's (IHPA) consultation on the development of the Australian Emergency Care Classification (AECC).

ACEM is the not-for-profit organisation responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak professional organisation for emergency medicine, ACEM has a vital interest in improving the quality of training and clinical supervision of its Members, while ensuring the highest standard of emergency medical care is provided for all patients.

ACEM welcomes the opportunity to engage with IHPA through this paper. Regarding the proposals outlined in the consultation document, ACEM provides the following feedback for consideration:

Question 1 – Are there any categories for level 1 that can be grouped together while remaining clinically meaningful?

ACEM considers that the majority of proposed AECC level 1 categories are clinically meaningful and require no significant change or grouping. However, the level 1 categories 'Did not wait' and 'Left at own risk' can often be confused as being interchangeable. ACEM suggests both categories require greater clarity to ensure there is no ambiguity about their use. ACEM considers the definitions below to be appropriate:

- 'Did not wait' applies to a patient who has been triaged but did not wait to receive treatment by an health care professional
- 'Left at own risk' applies to a patient who was triaged with assessment having commenced but left the ED against the advice of a health care professional, despite requiring ongoing care.

ACEM also questions the need to have 'Triage 1-2' listed under the 'Return visit, planned' category given the life threatening nature of a Category 1 (Cat 1) or Category 2 (Cat 2) patient presentation under the Australasian Triage Scale.[1] ACEM considers Cat 1 or Cat 2 patient presentations would not be applicable under a 'Return visit, planned' AECC category.

[1] Australasian College for Emergency Medicine. Background paper – Guidelines on the implementation of the Australasian Triage Scale in emergency departments (G24). Melbourne: ACEM 2016

Question 2 – Are there any ECDGs that can be grouped together while remaining clinically meaningful?

ACEM considers that the proposed emergency care diagnosis groups (ECDGs) are clinically meaningful.

Question 3 – Are the variables included in the draft AECC relevant to clinicians, health service managers and other stakeholders?

ACEM considers that the variables included in the draft AECC are relevant to ED clinicians.

However as noted in previous submissions, the continued inclusion of triage as an element of the emergency care classification is not supported. Triage is only used to describe clinical urgency. Other variables within the draft AECC reflecting factors such as severity, complexity and workload are far more appropriate in assigning and thus determining the cost and resources associated with an emergency department episode of care.

Question 4 – Are the end classes included in the draft AECC relevant to clinicians, health service managers and other stakeholders?

ACEM considers that the majority end classes included in the draft AECC are relevant to ED clinicians.

ACEM has identified the following classifications listed under the ECDGs by the ICD-10-AM short list, as requiring further consideration and action:

ECDG	ICD-10-AM shortlist	Comment / action
B64: Delirium/confusion/acute encephalopathy	R418: Symptoms involving cognition and awareness, other	Remove – ambiguous
B70: Stroke and other cerebrovascular disorders	G819: Hemiplegia I64: Stroke, cerebrovascular accident (CVA)	Combine – effectively the same
B81: Disorders of the nervous system, other	G448: Headache syndrome, other R51: Headache, other	Combine – effectively the same
E61: Major respiratory diagnosis	J80: Respiratory distress syndrome	Remove – unclear to its relevance in the ED
E65: Chronic obstructive airways disease	J449: Chronic obstructive pulmonary disease (COPD), other	Remove – not relevant in ED
E753: Respiratory disorder, other	J180: Bronchopneumonia, organism not identified	Remove '*organism not identified*' as not relevant
	J181: Pneumonia, lobar, organism not identified J18: Pneumonia, organism not identified	Remove – already captured in the above classifications: J129 J159
F75: Circulatory disorders, other	I259: Ischaemic heart disease, chronic (atherosclerotic)	Remove – captured elsewhere under F75
G661: Gastrointestinal peritonitism/perforation	K5780: Diverticulosis, with perforation or abscess	Remove '*with perforation or abscess*'
G662: Abdominal pain	K389: Appendix disease, other	Remove – already captured under G661 (K358 and K37)

G702: Digestive system disorders, other	K20: Oesophagitis, with or without gastro-oesophageal reflux disease (GORD) K219: Gastro-oesophageal reflux disease (GORD), without oesophagitis	Combine Question the relevance of these items as they are not diagnosed in the ED.
I01: Major injury, incl. multi-trauma	S079: Crushing injury of head	Clarification needed to ensure relevance of this classification
	S18: Amputation, traumatic at neck (decapitation)	Remove and/or replace with dead on arrival (DOA)
	S281: Amputation, traumatic or part of thorax (chest)	Remove – diagnosis not meaningful
I05: Injuries, other	S312: Wound, open of penis S313: Wound, open of scrotum or testes S314: Wound, open of vagina or vulva	Recommend an additional classification of 'closed' for S312, S313 and S314.
K62: Miscellaneous metabolic disorders	E299: Testicular dysfunction	Remove – not relevant to ED
T63: Viral illnesses	B03: Smallpox	Remove – no longer relevant as it is eradicated
T64: Infectious and parasitic diseases, other	A923: West Nile (Kunjin) fever A980: Crimean-Congo haemorrhagic fever, quarantinable	Although these are reportable under the *Australian national notifiable diseases case definitions*, they are not relevant diagnosis in an ED
X61: Allergic reactions	T783: Oedema, skin, subcutaneous tissue, muscle	There is a need to clarify this classification with *angioedema* and *angioneurotic edema*.

Question 5 – Are the proposed data items for the future version (s) of the AECC feasible to collect and report nationally?

ACEM considers that the proposed data items for the AECC are feasible to collect and report nationally. However, ACEM questions if the data collected will be used solely for the AECC or whether it will be incorporated into other reporting outcomes. ACEM requests that further information on this matter is provided to stakeholders at the proposed workshop in early 2018.

In addition ACEM also considers it essential that support is provided by jurisdictions and/or IHPA to hospitals, in jurisdictions that adopt the AECC, to ensure integration of the classification model into existing IT infrastructure.

Question 6 – What is the feasibility for emergency services to collect an aggregated list of diagnosis codes? If feasible, what level would be appropriate?

ACEM suggests that the feasibility for hospitals and EDs to use the AECC will be impacted by the time to collect data and the system's interoperability with the ED and hospital. To support this outcome, it is important that jurisdictions and/or IHPA ensure adequate resourcing is provided to reduce the impact on staff to undertake their clinical responsibilities.

Question 7 – What other issues should be considered in the development of the AECC?

ACEM highlights that the nature of ED presentations are symptom based, involving differential diagnostic procedures by clinical specialists, often without a known final (ICD) diagnosis in mind. ACEM recommends that the final AECC is flexible to reflect this clinical need. For example, if an ED specialist does a number of investigations to diagnose a blood clot (pulmonary embolism) on the lung, it will get a discharge code of pulmonary embolism. However, if the same ED specialist does the same work up with a different patient and rules out pulmonary embolism, the resulting code would be 'chest pain non-specific'.

ACEM also suggests that further amendments could be made to the ICD-10-AM short list. This could be achieved by having a number of senior FACEMs review the list against the ECDGs and provide IHPA with a revised version. ACEM is willing to work with the IHPA to achieve this outcome and any impact this would have on the development of the AECC.

Thank you for the opportunity to provide feedback to this consultation. Should you require clarification or further information, please do not hesitate to contact the ACEM Policy Manager Fatima Mehmedbegovic on (03) 9320 0444 or via email at Fatima.mehmedbegovic@acem.org.au .

Yours sincerely,

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