Attachment 1

WA Department of Health comments on the Development of the Australian Emergency Care Classification public consultation paper

WA Health has reviewed the public consultation paper and specific comments relating to the consultation questions are outlined below.

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

   Western Australia suggests that 'Died in the emergency department' and 'Left at own Risk' be removed from level 1 and include them under 'Emergency Presentation'. In both instances the discharge information would capture that a person passed in Emergency Department (ED) or that they left at their own risk; either following treatment, or prior to being seen, after having been triaged.

   'Return visit, planned' classification assists services like WACHS if there are provisions for outpatient clinics/remote area nursing/nurse practitioners built into the model as this is currently an area of concern. Perhaps a third level of complexity needs to be added, e.g. Triage 1-2, Triage 3-5 and Outpatient.

2. **Are there any ECDGs that can be grouped together while remaining clinically meaningful?**

   No comment

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

   The variables are meaningful to clinicians and are currently collected.

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

   Yes, the proposed end classes would be relevant, noting that the AECC would also be useful for benchmarking against other facilities on a like to like basis.

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

   Emergency care data are collected using two systems:

   (1) Emergency Department Information System (EDIS) for metropolitan hospitals and 1 regional hospital; and

   (2) Web-based Patient Administration System – Emergency Department (web-PAS-ED) for all hospitals within the WA Country Health Service.

   The proposed data items may be feasible for facilities using EDIS, but technical enhancements would be required for hospitals using webPAS-ED.

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

   It is feasible for emergency services (as in small rural hospitals) to collect aggregated list of diagnosis codes in the form of ICD10-AM codes.

7. **What other issues should be considered in the development of the AECC?**

   IHPA should mandate adoption of the national standard list, which is currently in final draft formulation.

   The cost associated with caring for transit patients, particularly for rural and remote areas, may not be effectively captured under the proposed model (i.e. Broome patient being transferred to Perth requiring a stay in Port Hedland for 3 hours). These transit patients could be added as a level of complexity under 'Referred to another hospital'.