Submission to the Independent Hospital Pricing Authority 1st December 2017

Re: Development of the Australian Emergency Care Classification - public consultation paper

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I was sent these documents with only a week to go before submissions were due - given that I work up country it means I won't have sufficient time to give them a proper reading.

Consultation Questions:

1. Are there any categories for level 1 that can be grouped together while remaining clinically meaningful? **not that I can see**
2. Are there any ECDGs that can be grouped together while remaining clinically meaningful? **I don't have enough time to assess**
3. Are the variables included in the draft AECC relevant to clinicians, health service managers and other stakeholders?
4. Are the end classes included in the draft AECC relevant to clinicians, health service managers and other stakeholders?
5. Are the proposed data items for the future version(s) of the AECC feasible to collect and report nationally?
6. What is the feasibility for emergency services to collect an aggregated list of diagnosis codes? If feasible, what level would be appropriate?
7. What other issues should be considered in the development of the AECC?

General Comments re 7

The variables will always need to contain age, admission status, mode of transport to ED, and triage category. But these are all ACUTE variables and take little notice of how unwell the patient was before they got sick. I don't think these take into account the underlying complexity of the patient.

Every new illness is layered over how sick they were in the first place. There is no overall assessment of the sickness of a patient except in acute illnesses.

Along with a couple of Professors at Newcastle University NSW, I am trying to put together measures of complexity of chronic illnesses and give a weighting to them so that we can score patients as to how much burden of illness they have, and therefore how complex they are. Giving a simple script for anti-arthritics can be quite complex in a person with heart failure or kidney disease. Frailty scores are almost never used in hospitals but we know that as people get older and frailer they use more resources.

I would like to be involved in future developments on clinical scoring of severity of illness, as a substantial burden of our workload relates to complexity of old and sick people, none of which is routinely measured.

Regards

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