Independent Hospital Pricing Authority Consultation Paper
Development of the Australian Emergency Care Classification

NSW Health Submission

This submission provides comment on the Consultation Paper prepared by the Independent Hospital Pricing Authority (IHPA) regarding development of an Australian Emergency Care Classification (AECC).

General Comments

NSW supports the move towards a new patient centric classification for emergency services in Australia and recommends that emergency department services are not priced using the AECC until sufficient cost data is available.

NSW queries whether there has been a validation of the emergency care diagnosis groups. NSW recommends that further validation studies be undertaken to test the cost impact as well as review the quality of the source data to ensure that it is suitably robust.

Chapter 4: Draft AECC

Consultation Question:
1. Are there any categories for Level 1 that can be grouped together while remaining clinically meaningful?

NSW is of the view that the categories should be grouped based on supporting data. Visit type was found to be statistically a poor predictor of costs. If it is considered that the Level 1 breakdown is not a reliable predictor of cost, then it should be reconsidered as the first split in the hierarchy. NSW notes that the principle of the categories is based on clinician logic, however the data must support the groupings to be statistically relevant.

If visit type is retained then clear rules and standards will be required for implementation of Level 1 as the categories are not all mutually exclusive. They will rely on a mix of visit type and disposition status to enable allocation to the appropriate Level 1 group.

NSW recommends further consideration of transport mode as an appropriate variable and cost predictor, particularly for transfer patients. NSW clinicians have suggested that mode of transport such as the Royal Flying Doctor Service, other fixed wing, ambulance or private vehicle, would better predict cost and therefore would be a more appropriate variable than triage category for this cohort. Alternatively, source of referral could be statistically tested as a potential variable.

NSW notes that any changes to the triage process would need to be reflected in the AECC for the classification to remain relevant.

Consultation Question:

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

NSW notes that the ECDGs are generally understandable; however, the close association with AR-DRG may cause confusion for clinicians. NSW recommends that IHPA undertake further consultation regarding the nomenclature of the classification.

NSW clinicians have noted that there are some examples of ECDGs where simple symptoms have been grouped with complex diagnoses, for example B81 includes both R252 (cramp or spasm) and G610 (Guillain-Barre syndrome). This grouping is not likely to have validity from a cost variation perspective, nor is it clinically valid. It is unlikely to meet the clinically meaningful and resource homogenous principles outlined as the basis for the classification.

Further concern has been raised regarding Z611 'Falls Risk' as it maps to 'Dizziness'. Falls Risk has multiple aetiologies and Dizziness is one of the least frequent.

Consultation Question:

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

The variables are considered to be relevant to clinicians, health service managers and other stakeholders, noting the concern with the naming conventions used in the classification (i.e. ECDGs).

NSW clinicians noted that triage category 3 is more closely aligned from a cost perspective with triage categories 1 and 2 rather than triage categories 4 and 5. NSW recommends that IHPA consider grouping triage category 3 with triage categories 1 and 2, or as its own category.

Consultation Question:

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

Clinicians do not consider the end-classes to be relevant. The end classes would have relevance to health service managers and other performance-related stakeholders.

The draft classification is considered more complex than the UDG/URG classifications and the variables are inconsistently applied to the ECDGs. This is compounded by the clustering of different end nodes into the complexity groups A-D, so that variables identified in the model do not truly correspond to different end-classes. End classes that have no split should be given a unique nomenclature that indicates no complexity split is applicable.

Chapter 5: Next Steps

Ongoing Development of the AECC

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

NSW agrees that the proposed data items may be suitable however significant effort would be required in relation to the method of collection. These data are not currently reported or extracted and changes to source systems and documentation standardisation would require significant lead time (three to five years). Innovative ways to source the data also need to be considered such as data scrapping or text matching from eMRs, especially as there is insufficient coder workforce. Classification requirements should not increase the administrative burden of front line clinicians.

Applicability to Emergency Services

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

NSW agrees that it may be feasible for emergency services to collect an aggregated list of diagnosis codes. It is recommended that consultation be undertaken with emergency services clinicians to determine what is included on the aggregate list and the timeframe needed to ensure that all are able to transition if they currently do not collect diagnosis electronically.

Data Development

Consultation Question:
7. What other issues should be considered in the development of the AECC?

As diagnosis is the major axis of the classification, it is recommended that IHPA provide sufficient supporting materials to assist clinicians in using appropriate diagnosis codes as required under the implementation of the classification. A shortage of clinical coders will place further pressures on emergency department clinicians to allocate diagnoses from the clinical coding shortlist. Errors in diagnosis selection have the potential to disrupt the efficacy of the classification.

The role of clinical documentation specialists will be essential for instructing and educating clinicians to facilitate consistency and standardisation of diagnosis selection at the local level. It is believed that there will be a need to monitor the consistency of diagnosis choice due to the current composition of the workforce.