Consultation Question	Response
1. Are there any categories for level 1 that can be grouped together while remaining clinically meaningful?	• SCHN holds the view that the proposed categories used in Level 1 should not be grouped any further. • SCHN proposes that the source of referral be considered as another category in Level 1 (or used to adjust/determine the end classes under emergency presentation). Emergency presentations which have been referred to SCHN facilities are often more complex and resource intensive. • SCHN proposes that some of the single end class level 1 categories be split with consideration of the additional resources required in the paediatric setting. o For Dead on arrival, there are greater resource requirements (senior medical staff, social workers, multiple nurses for family support, on call paediatricians required to complete unique paperwork such as SUDI documentation). o For Left at own risk, there are Child Protection considerations that involves additional resources (time spent in ED, Child Protection staff etc.)
2. Are there any ECDGs that can be grouped together while remaining clinically meaningful?	• SCHN does not believe that ECDGs can be further grouped/ • SCHN comments there are some examples of ECDGs where simple symptoms have been grouped with complex diagnoses e.g. ECDG B81 includes both R252 (Cramp or Spasm) and G610 (Guillain-Barre syndrome). From a costing perspective, this would result in a large difference in resource utilisation within the same ECDG.
3. Are the variables included in the draft AECC relevant to clinicians, health service managers and other stakeholders?	• SCHN agrees with the variables that have been considered in the draft AECC and consider them to be relevant drivers of cost. • SCHN comments that for triage categories, Category 3 is more closely aligned to Categories 1 and 2 in terms of resource usage and proposes IHPA investigate impacts to end classes by combining Triage categories 1-3.
4. Are the end classes included in the draft AECC relevant to clinicians, health service managers and other stakeholders?	• SCHN does not believe the end classes are relevant to clinicians, health service managers and other stakeholders. Some of the concerns include: o Whilst the variables used in determining complexity are relevant, the manner in which they have been applied differently for each ECDG makes it difficult for the classification system to inform clinicians and health service managers about the impact of those variables on the cost of service delivery. This is further 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. o The use of the term complexity to describe the splits within ECDGs for end classes can be confusing and likely to be misunderstood as pertaining to the severity of the emergency presentation. Some end classes may be classed as complex but are representing additional costs incurred in the ED for treatment of less severe presentations (more interventions taking place in ED so patients can be discharged).
5. Are the proposed data items for the future version(s) of the AECC feasible to collect and report nationally?	• SCHN holds the view that collection of a well-defined list of diagnosis modifiers, interventions and procedures is feasible, with the caveat that it must be supported by the technology in the LHDs (e.g. designated drop down menus in EMR). This would ensure consistency of data collection, ease of extract and reporting with minimal impact on clinician time. • SCHN comments that some of this data is already collected however these fields are not mandatory. • SCHN proposes the addition of Child in Out of Home Care be considered as a separate diagnosis modifier as this requires greater resource usage and greatly extends the length of the emergency department visit.

6. What is the feasibility for emergency services to collect an aggregated list of diagnosis codes? If feasible, what level would be appropriate?	• N/A
7. What other issues should be considered in the development of the AECC?	• SCHN comments that it agrees with the movement towards a diagnosis driven classification system as triage category is not the primary determinant of resource utilisation. • SCHN proposes analysis be undertaken using a wider sample of paediatric data. The data collected as part of the Emergency Care costing study and used to develop the AECC may not accurately reflect the following for paediatric facilities: o Variation in acuity (for example number of trauma patients in sample) o Variation in socioeconomic status, FACS involvement and Out of Home Care • The mean costs for paediatric age groups presented in the Emergency Care costing study does not appear to reflect some additional resources required in treatment of children in an Emergency department, such as: o Higher staffing requirements as often more than one clinical staff member required to complete even simple interventions with children (e.g. assisting in holding a patient during insertion of a cannula) o Greater time spent in emergency departments due to procedures / interventions taking longer or a preference for monitoring of patients over an extended period rather than performing diagnostic procedures immediately. o Paediatric patients often require sedation or local anaesthetic in situations where adult patients do not. • Clinical practice in emergency departments is governed by guidelines for certain types of emergency presentations (e.g. bronchiolitis, head injuries) – consideration in using these guidelines to inform classification development may be useful in aligning the classification system and clinical practice.