Response to the Independent Hospital Pricing Authority's Development of the Australian Emergency Care Classification

Victorian Department of Health and Human Services
December 2017

Introduction

Victoria welcomes the opportunity to comment on the Independent Hospital Pricing Authority's Consultation Paper on the development of the Australian Emergency Care Classification and supports the work of the Independent Hospital Pricing Authority to develop classifications for emergency care activity to increase transparency in funding.

Consultation question 1: Are there any categories for level 1 that can be grouped together while remaining clinically meaningful?

It might be possible to group "Did not wait" and "Left at own risk" level 1 categories and re-split by triage category. However, this approach would need to take into account whether treatment has started and/or left after receiving clinical advice.

Consultation question 2: Are there any ECDGs that can be grouped together while remaining clinically meaningful?

Victoria has previously provided comments on this issue which have been incorporated into this version.

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

The level 3 complexity splits are developed based on variables that are currently available in the National collection specifications. While it may be a desirable objective to mirror complexity splits in the AR-DRG classification, the reference to a 'complexity level' split might lead to confusion by decision makers, clinicians and researchers. For instance, triage, episode end status and arrival mode are not complexity measures, but those variables are more relevant to distinguishing differences in cost structures. While there may be some correlation between urgency and complexity, triage is not a process to identify complexity. Many of the complex and time-consuming patients come from the triage categories 3 and 4, in particular, many of the elderly patients with multiple problems fall within these categories.

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

The end class attributed to "Died in the Emergency Department" is not likely to reflect differences in workload or costs. While there is a reasonably predictable amount of work involved in managing a death, the work done before-hand can be variable. For instance, a patient that dies may have commenced active resuscitation or the work may have only involved brief palliation. Consideration should be given to splitting this end class to reflect the different cost structures. The end classes "Referred to another hospital" and "Left at own Risk" are split on triage only and so are also unlikely to reflect differences in the work-load prior to the transfer or self-discharge.

While some of the end classes are split based on age, it is expected that complexity would more likely align with the extremes in age groups (less than 5 years and greater than 85). At the face of it, the proposed classification does not appear to reflect that expectation in that the splits are more likely based on the differentiation of costs rather than complexity.

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

With regard to diagnosis modifiers generally, Victoria notes that the guides for use are quite detailed and whilst they may be useful for some, they may also cause confusion for the staff having to collect the information in the emergency department and therefore may impact on the quality of the information collected.

The code descriptions in guide for use for Diagnosis modifier – body mass index would be better described as 'has, or is assessed as having' a BMI of 40 or more (or less than 40). The current definition implies that it has been measured but it is only required to be measured when there is uncertainty.

With regard to Diagnosis modifier - residential care resident consideration should be given to excluding references to 'aged' care and to 'older' persons as not all residential facilities are aged care facilities.

Victoria considers the list of procedures comprehensive but would need to be updated in keeping with the main procedures performed in an emergency department if this changes over time.

A draft grouper for the proposed classification system would likewise assist jurisdictions interrogate the local data to assess data collection requirements, as well as to assess the impact of a transition away from the URG classification system currently used in the national emergency funding model.

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?

Victoria currently collects diagnoses from a pre-defined list and supports the introduction of the ED ICD-10-AM Principal diagnosis short list for national consistency.

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

Victoria generally needs a minimum lead time of six months to incorporate changes to the local emergency data collection requirements.

As emergency departments in Victoria do not have the same software, this lead time may need to be longer depending on the software's flexibility. The cost of software changes may also impact on the emergency departments' ability to implement changes as well as vendor status, that is, whether the vendor still offers support for their product.

In summary, Victoria is supportive of this important classification development work. However, the Independent Hospital Pricing Authority should consider the impact of describing the end group splitting as reflecting severity and/or complexity (consequently reflecting resource use). In particular, the long term value of this development work may be undermined if clinicians and researchers are unable to establish a link between the classification in its current form and the complexity of a presentation observed in the emergency departments.

Rather, the end group splitting process should, at this stage, be described as reflecting resource use with a desire in the long term to use clinically relevant complexity measures that will eventually be reported to a refined *Non-Admitted Patient Emergency Department* Care National Minimum Data Set.

The development of a grouper for this classification would also allow jurisdictions to quantify the impacts of this development work on both national and local funding models.