Consultation: Australian Non-Admitted Care Classification Submission regarding Clinical Terminology - Australian Digital Health Agency

12 April 2018
Approved for external information

Submission summary

- We agree with requirement to revamp how non-admitted care data is collected and subsequent funding of services.
- We agree with change of focus toward a patient-centric data model
- We agree that the classification needs to account for advances in digital health
- Further consideration by IHPA and policy makers such as AIHW and the Department of Health is required in consultation with the Australian Digital Health Agency to ensure alignment with the National Digital Health Strategy especially with regard to section 3.2.2 (discussed below)

Background to submission

Clinical terminology such as SNOMED CT-AU as a foundation of health records supports evidence-based care and facilitates improved safety and patient outcomes, better co-ordination of care and greater cost-effectiveness. It allows for meaning-based retrieval of clinical information to conduct effective analyses for both retrospective and prospective secondary use cases and are key to the successful delivery and realisation of the benefits of many of the national digital health strategic priorities including:

- *Health information that is available whenever and wherever it is needed;*
- *High-quality data with a commonly understood meaning that can be used with confidence;*
- *Better availability and access to prescriptions and medicines information; and*
- *Digitally enabled models of care that drive improved accessibility, quality, safety and efficiency*.

Adoption of terminology involves a complex interaction between clinical and business needs, government policy & regulation (e.g. Activity Based Funding), investment priorities of healthcare funders and business and technology development by software vendors – across both public and private sectors.

In order to achieve comprehensive clinical system interoperability across the Australian healthcare sector, the adoption and maturity of the implementation of standardised national terminologies must be increased which requires ongoing collaboration with related organisations to identify and remove barriers.

Focus area of feedback:

"*IHPA acknowledges that the information to be captured for the purpose of classifying non-admitted care should not require a separate coding workforce*."(Section 3.2.2).

To meet this requirement, there needs to be further consultation on how data is obtained for the purposes of classification. Current IHPA processes do not adequately specify/consider the input data and if not changed the burden and cost of setting up new systems may be substantial.
A classification will not provide the appropriate level of detail for clinician input into software systems at the point of care and requires further consideration.

As described in the paper, dedicated coders (in acute settings) read clinical notes and undertake the coding process. With the progression of digital health, clinicians are now recording data using clinical terminologies (e.g. SNOMED CT-AU and AMT) and inputting this information into Clinical Information Specifications. If the classification is to become automated then these inputs need to be considered as part of automation.

The aim of "digital transformation will create new opportunities for the capture of non-admitted care data" (section 3.2) will only be fully realised if the classification is developed with national clinical terminologies as input data and streamlined where possible with the emerging clinical information specifications/data elements already being used/developed in the industry.

If it does not take these into account it will limit the national digital health agenda and impede improvements.

Yours sincerely

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