Response to IHPA's Australian Non-Admitted Care Classification Development public consultation paper

1. **Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?**
    - Yes
    - Enable the capture of activity undertaken by various providers including those services supplied by contracted or public private partnerships.
    - This will be dependent upon digitalisation and setting the expectation that patient service event codes are recorded at the EMR / EHR and available at the PHR level.

2. **Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?**
    - Yes
    - This will be dependent upon digitalisation and setting the expectation that patient service event codes are recorded at the EMR / EHR and available at the PHR level.
    - Point of care delivered by Health Professionals other than doctors, including telehealth.

3. **As the types of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes?**
    - A patient complexity risk matrix scoring SNOMED building upon current practices such as aged care assessment tool and similar.
    - Appropriate transition period timeframe to allow for the 'change in process burden' for non-admitted patients.

4. **The classification principles have been designed to guide and support the development of the future classification, do you agree with these and/or are there other principles that should be considered in developing ANACC?**
    - Yes
    - The current Tier 2 non-admitted services classification provides three classes to which all radiation oncology services must be attributed (10.12, 10.20 and 20.43). This taxonomy offers limited availability to accurately align the widely varying costs of such services with an appropriate quantum of revenue. There is no mechanism for stratifying the burden of care into more granular categories. The NHS approach offers an example of a more nuanced classification for radiation oncology. It

distinguishes services by the equipment used to deliver treatment, the complexity of the patient's condition and the phase of care. We propose that non-admitted radiation oncology services be revised to include a stratification of service levels.

5. **Should IHPA continue to use service event as the ANACC unit of count? If yes, do you agree with the proposed revised definition of a service event? How could it be improved?**
    - Yes
    - Feel the revised definition incorporates the various models utilised by cancer care services.

6. **Should an episode be considered as a unit of count in the new ANACC? If not for all conditions, then for which specific conditions?**
    - Yes
    - Malignant disorders
        - E.g. Breast Cancer –
            - Surgical - wide local excision
            - Radiation Therapy - 35 visits
            - Systemic therapy (Chemotherapy) 19 visits
            - Survivorship (follow up) 10 visits

7. **Non-admitted patients often present with multiple comorbidities, and may be treated under a chronic disease management model. Should the future ANACC system have a separate path for classifying chronic disease patients?**
    - Yes - definitely.

8. **What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?**
    - Queensland's single ieMR build will enable a more feasible process to report patient level data by 2021.

9. **What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?**
    - Consensus and Standardisation of SNOMED codes plus an information standard that requires recording at point of care, reporting and sharing with PHR.
    - Compliance with ISO 9001:2015.

10. **Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'?**
    - Yes, however 'presenting problem' also needs to be standardised e.g. SNOMED.

11. **What are your views on the proposed list of initial presenting problem/diagnosis-type and intervention-type groups presented at Appendix A? What refinements should be considered?**
    - MDC 17 be adjusted to include **only** Haematological neoplastic disorders and other solid tumour neoplasms be a separate option.
    - Inclusion of Oncology Treatment as a proposed intervention-type groups;
        - Malignant Diagnosis
            - Surgical
            - Radiation Therapy
            - Systemic Therapy (chemotherapy / antineoplastic therapy)

12. **Do you agree with the list of complexity variables presented in Section 5.3? What other variables should be considered for the new ANACC system?**
    - Yes
        - Include a stratification complexity (acuity) matrix

If you have any questions please contact Tracey Palu or Maree Bransdon at CIRCS@health.qld.gov.au