

Mr James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
By email: submissions.ihpa@ihpa.gov.au



Dear Mr Downie,

Re: Australian Non-Admitted Care Classification Development

Thank you for the opportunity to provide feedback on the stakeholder consultation paper for the proposed Australian Non-admitted Care Classification (ANACC). As you know, Children's Healthcare Australasia's (CHA) membership comprises both specialist children's hospitals and general hospitals providing paediatric services, large and small. We have consulted our members about the questions posed in the consultation paper on the proposed Non-Admitted Care Classification. This submission offers feedback related only to children's services non-admitted care.

CHA supports IHPA's efforts to develop a non-admitted care classification that is better focused on patient need rather than on simply the type of clinic the child attends. A classification that captures data on patient complexity in non-admitted care will also be helpful in analysing effective models of care for children and their families, especially for those children with complex healthcare needs accessing multiple outpatient services, in hospital clinics, in the community and in the home.

IHPA is seeking written comments on the following questions:

1. Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?

CHA supports strategies to improve the integration of care between healthcare settings, removing silos of care and breaking down professional boundaries to create more seamless care delivery for children and their families. CHA supports the introduction of unique patient identifiers to allow for more accurate data collection and enable services to track activity across multiple settings, allowing greater understanding of care trajectories for different patient groups.

CHA already works with member organisations to benchmark performance in inpatient and outpatient settings. Improving the consistency & clinical granularity with which services collect non admitted patient data will enable services to more effectively monitor their performance and develop strategies to improve the efficiency and effectiveness of their service delivery for children.

CHA does not have the answer to 'how' such integration could best be achieved. But ideally, the use of descriptors of children's clinical need and care in non-admitted settings should be readily

linkable to the inpatient care classification where hospitalisation is an expected or typical part of a given care journey. The My Health Record will be one tool for sharing information among providers and across settings, but there will remain a need for the outpatient data classification to enable data to be captured in a consistent way across settings and among providers. Our members appreciate that this will involve significant investment in data capture by clinicians and by services and may take some time to achieve.

A further consideration in this context is Hospital in the Home services. Most HITH services are currently organised around adult patients and their needs. There is a small population of chronically unwell and dying children who, together with their families, require HITH services, such as home based ventilation or palliative care. Current ways of capturing activity & of funding such services pose a significant barrier to the provision of these services in many jurisdictions. There will always, thankfully, be relatively small number of paediatric patients requiring this form of care but that should not be a reason for failing to deliver such services to paediatric patients. Ensuring the ANACC captures and enables such care for children will be one significant element in supporting such children and their families to access home based care as needed.

2. Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?

It is clear that the non-admitted classification will need to be designed in a way that anticipates changes over time. The difficult question is how. The classification will no doubt be revised over time to respond to new developments, so the structure will ideally be designed in a way that it is amenable to adaptations over time.

Certainly children's services are increasingly looking to innovative ways to deliver non-admitted care, support hospital avoidance for children with chronic conditions, and facilitate access to paediatric expertise as close to home as possible. Use of telehealth is on the rise, not just between families and sub-specialists in children's hospitals but also between regional base hospitals and rural/remote services with demonstrable benefits in terms of improving the timeliness and quality of access to paediatric expert care, as well as reducing the costs & burdens of avoidable transfers.

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?

Presumably there will be need for ongoing regular review of the design of the ANACC which can take into account changes in practice over time. In any event, there are some types of care that should be setting agnostic. For example, as innovative models of care are implemented children with chronic conditions such as diabetes and arthritis and their families will expect to access good quality and complex care in a range of locations, particularly those close to home or places of work or study to reduce disruption to education. Ideally, a national non-admitted care classification should be used consistently across care providers and funding models, in much the same way that the inpatient classification is consistent across public and private patients, and public and private hospitals.

CHA members are in favour of the introduction of additional data items for the counting, costing and classification of non-admitted multidisciplinary case conferencing where the patient is not present. Multi-disciplinary case conferences form a vital adjunct to the clinical care of patients with conditions that are long-term and complex. The complex, on-going nature of their illness means it is better that care is co-ordinated to ensure that children are provided services in a consistent and coordinated manner with a shared treatment goal between all within the care team. These children have the potential to deteriorate quickly, and subsequent hospital re-admission/s are a potential adverse outcome of loss to follow-up. A number of our members have achieved demonstrable reductions in ED presentations and unplanned admissions by patients with complex care needs following efforts to better coordinate care across specialties through multi-disciplinary case conferencing. The positive health benefits gained from multidisciplinary case conferencing where the patient is not present, far outweighs the cost of funding unplanned admissions that can be required when such conferencing is not undertaken.

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?

The principles are appropriate and relevant. Given the admirable intent of the ANACC to evolve with evidence based practice changes, CHA is particularly supportive of the principle of 'minimising undesirable and inadvertent consequences'. It is evident from our benchmarking activities and the static nature of some healthcare practices that funding methodology has contributed to inhibit innovation and evolution of practice in some areas of healthcare for children. Better mapping the costs of providing non-admitted care to patient complexity and need, particularly if the classification is setting and provider agnostic, will be an important step toward enabling more efficient and targeted non-admitted care.

CHA suggests the addition of one additional principle related to the need to ensure this classification will integrate with others, such as the inpatient, emergency and mental health care classifications. For example, it will need to be clear if care of an adolescent receiving non-admitted follow up care post-acute admission for medical management of an eating disorder, is to be captured under the ANACC or the AMHCC. The importance of the classifications complementing one another is clearly articulated in the consultation paper.

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?

CHA supports IHPA's revised definition for service event. The expansion of the interactions types to include multidisciplinary case conference where the child & family are not present and those that may occur in the child & family environment without the presence of the health professional are welcomed. CHA supports IHPA's proposed approach of retaining the use of service event as the unit of count for the introduction of the new classification, then considering the use of episodes later on, once data has been collected for a few years and costs evaluated.

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?

Children's health care will benefit from the use of episode as the unit of count. In particular patients with chronic health conditions and complex care needs will benefit from this count type for funding as it will assist health planners to determine where additional resourcing is required to support effective healthcare interventions. For example, children with chronic conditions are often times provided social work and psychological services in an ad hoc manner within clinics with further therapeutic services provided outside scheduled clinics only as resources allow. Use of episode as unit of count will provide opportunities to allocate resources more effectively for these patient groups.

CHA acknowledges that it will be challenging for IHPA to determine a costing methodology outside the unit of service count type but believe it would be a progressive step and would certainly support innovative practice and timely introduction of evidence based care models. A classification system consistent with the current admitted classification where the complexity of a child's care could be captured and recorded as A, B or C would also be of value, although this will involve a significant change in outpatient service design & data systems.

In the instance that IHPA progresses with use of episode as unit of count for chronic conditions only, CHA does not support the proposal by IHPA to use the AIHW chronic care groups as these would be limiting for children's services since they focus on predominantly adult health chronic conditions*. Examples of chronic conditions more relevant to children would be Cystic Fibrosis, metabolic conditions, autism, developmental delay and growth failure/malnutrition. This list is not exhaustive and CHA can seek further advice from members should IHPA find this beneficial.

*AIHW chronic care grouping = arthritis, asthma, backpain, cancer, cardiovascular, COPD and diabetes.

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?

CHA would be supportive of there being stronger provision within the new ANACC for describing and pricing care for children with rare and chronic diseases. However, children with complex issues and chronic diseases are rarely treated under the chronic disease management model. We believe that rather than having a separate path for classifying chronic disease patients it may be better for the classification to allow for appropriate capture of higher complexity of non-admitted care, and analyse the cost true costs of such care and to price such higher complexity accordingly.

We would welcome the opportunity to better identify these children in activity datasets and better capture the costs involved in providing their care. Typically a wide range of multidisciplinary expertise is required for these children and their families and can occur across their entire childhood and then into adulthood.

8. What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?

CHA has no comment on this, other than to flag an interest in seeing implementation progress in as uniform and timely a way as possible. No doubt jurisdictions will determine their own timetables. And hospitals where children receive non-admitted care vary considerably in their access to electronic health systems. The development of this new classification will directly influence the data that is collected and shared, and therefore the opportunity for individual services, and organisations like CHA, to identify effective models and the potential to improve outcomes and lower costs of providing children's healthcare services. However, our members are anxious to ensure that the transition period is sufficient to enable them to have reliable ways of capturing non-admitted activity under the new classification before funding is linked to this. Since resources for paediatric non-admitted services are typically hotly contested in large adult-focused health services, children's healthcare providers are anxious to ensure they can continue to be funded for existing care at the very least, while a new system is introduced & implemented.

9. What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?

CHA agrees that the main reason for any patient to receive a non-admitted care service should be the first and dominant variable in a patient-based classification system, as it provides scope for non-admitted occasions of service to be patient focused, to occur in the absence of a diagnosis, and to reflect the patient's need.

CHA acknowledges that presenting problem is a term that will be well understood by clinicians and is consistent with clinical documentation of a variety of health professionals making it an ideal diagnosis-type variable. There are however circumstances where the term "presenting problem" will not clearly describe the reason for encounter. Examples include, but are not limited to, routine monitoring of chronic health conditions and developmental checks for babies and young children. There will need to be clear examples of how to apply this term within classification documentation.

CHA acknowledges the additional data burden likely to arise from introducing a diagnosis-type to recording of non-admitted care. However we believe the benefits will outweigh the costs in the medium term.

10. Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'?

Presenting problem is an ideal term to be used for children's healthcare as many children often go through a lengthy investigation phase with multiple healthcare providers prior to diagnosis. CHA is supportive of the proposed definition and agrees that guidance and business rules will be valuable to ensure consistent recording of this information. It will be important to include within this guidance how presenting problems are superseded with further more definitive diagnosis once this occurs.

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?

CHA members have made a number of suggestions for refinements that should be considered in relation to non-admitted care to children. Some of the types of 'presenting problems' particularly relevant to paediatric patients that should be considered for inclusion are:

- Developmental difficulties e.g. developmental delay, enuresis/encopresis
- Behavioural problems e.g. ADHD, ODD, conduct disorder
- Learning and intellectual disorders
- Neuro-developmental disorders e.g. autism spectrum disorder
- Infant related disease/difficulties e.g. irritability, sleep and settling problems
- Chromosomal, hereditary and syndromal diagnoses e.g. chromosomal disorders, Down syndrome, other complex multi system syndromes
- Specific adolescent medicine issues e.g. sexual identify issues, puberty related diagnoses
- Psychosomatic or chronic rheumatological diseases e.g. chronic fatigue, complex regional pain, conversion disorders, factitious disorders
- Forensic medicine e.g. child sexual assault, emotional neglect, out of home care cases, non-accidental injury
- Nutritional disease e.g. failure to thrive, feeding difficulties

CHA would encourage IHPA to develop the ANACC with the broad range of paediatric and neonatal diseases that reflects the complexity of care provided on a regular basis in our non-admitted care services.

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?

In an ideal world, complexity would be captured through clinically relevant datasets. CHA acknowledges, however, that clinical complexity is not able to be captured & used for costing & funding purposes due to a range of practical challenges, like the feasibility of collecting relevant data. In the absence of clinical descriptors of complexity, CHA supports the classification in its first version using the variable as proposed: – age, comorbidities, multidisciplinary, new/review, provider. Members also queried whether consideration should also be given to including two additional variables as Aboriginal and Torres Strait Islanders and CALD (culturally and linguistically diverse), as these groups of children are typically more resource intensive.

It is well documented that Aboriginal and Torres Strait Islanders suffer significantly from poorer health outcomes. Issues for Aboriginal and Torres Strait Islanders extend beyond comorbidities and age. Inclusion of this variable would provide a valuable health planning tool and allow the health system to track provision of services to Aboriginal and Torres Strait Islanders in a much more transparent and meaningful way. Although it is acknowledged that this variable is already captured within patient administration systems for those whom identify as Aboriginal or Torres Strait Islander and may not be suitable for inclusion in the classification per se.

Children and families from CALD backgrounds require additional communication strategies including but not limited to interpreting services to understand the impact of their health condition and to navigate the health care system. Inclusion of this variable will allow health planners to factor

into their resource allocations appropriate levels of required services and supports for these patients within their communities. Patient administration systems already indicate in varying ways patients needs for interpreters and as such a modification of these fields to align with the ANACC could be implemented by health services within existing systems.

Further information.

CHA would be happy to facilitate further discussion with members about these matters if you require clarification or further explanation for any of the comments provided here. Please don't hesitate to contact me if we can assist further. Thank you again for the opportunity to provide advice on these matters. We look forward to the next iteration of IHPA's consultations on this significant project.

Kind regards

A handwritten signature in black ink that reads "Barb Vernon". The signature is written in a cursive, flowing style.

Dr Barbara Vernon
Chief Executive Officer
Children's Healthcare Australasia

6 April 2018