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?
    a. Capturing the types of professionals involved eg. multidisciplinary team assessments (synchronous or asynchronous) to be embedded in data capture
    b. Capturing duration of clinical work be it **direct** eg face to face or **indirect** eg. case discussion/ conference, case management/ liaison
    c. Reduce duplication of entries – discipline involved in a clinic is captured under the same encounter not through their own individual allied health ABF reporting system. In the backend various mechanisms then enable to relevant discipline to be costed accordingly

2. Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?
    a. Yes – services not delivered in health care settings eg. home, school, NGO, day program, respite – need to account for travel time, number of staff involved, duration, time to do case management and liaison
    b. Need to review current way data is being captured and include fields in PowerChart that speak to the above (a) variations
    c. Telehealth MDT work should be captured as well and costed accordingly
    d. Capture intake process or any work done to prepare a patient for a health encounter OR post encounter
    e. Be aware that data captured upstream comes from a very complex data capturing mechanism from LHDs who are all setting up their systems very differently from each other – risk of errors and variability of data is high

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. A unfied system across all health districts, as closely as possible to real time so we can see all activity as timely as possible – we are all reporting through the same definitions and the cost calculations are standardised across all Districts (calculate local NWAU vs statewide NWAU should based on the same rules) – at the moment there is a lot of variability as to the interface and how data input is done and captured across districts – how do you then compare apples and oranges?
    b. For the SCHN - Phone calls and emails re clinical/ case management be captured and costed separately from face to face sessions
    c. Opportunities to revise and refine the system into the future

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?

a. Yes broadly so

b. Make data entry as efficient as possible – avoid duplication of work

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?

    a. Yes broadly but also take into account duration, number of persons involved and time working on patient outside of face to face encounters

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?

    a. Yes its ok

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?

    AIHW commonly reports on 8 major groups: arthritis, asthma, back pain, cancer, cardiovascular disease, chronic obstructive pulmonary disease, diabetes and mental health conditions. Does not include ID/autism, does not account for OOHC, in supported accommodation, other vulnerabilities refugee, carer with health issues, SES/ financial problems, other psycho social issues

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

    a. 3 years minimum

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

    a. Have a tiered system (primary, secondary etc)

        i. Include ID (some level of severity), Autism, GDD and

        ii. Mental health co-morbidities and other ADHD, ODD,CD, etc

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

    a. No presenting problem is the presenting variable. Diagnosis is made after the presenting variable has been through the assessment phase of the encounter – problem is if you mix presenting variable with diagnosis, it will be very difficult to extract accurate diagnostic info from the data

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?

    Sometimes the diagnosis is not apparent until after the clinical consultation. It may be better to list according to presenting problem. When developing diagnostic list have a tiered system of prioritisation eg primary diagnosis, secondary diagnosis etc. include psycho-social factors into the list as well

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?

    It should include family vulnerabilities eg. parental mental health, psycho-social issues, child protection concerns etc.