18 March 2018

James Downie
Chief Executive Officer
Independent Hospital Pricing Authority
PO Box 483
Darlinghurst NSW 1300

Re: Development of the Australian Non-Admitted Care Classification

Dear Mr Downie,

Thank you for the opportunity to contribute to the Development of the Australian Non-Admitted Care Classification.

I thank IHPA for undertaking this significant and essential development to evolve from the T-2 classification. It is encouraging to see the conversation moving towards the classification supporting the health system to be better integrated.

My feedback on the consultation paper follows on from the next page.

I wish IHPA and its advisory committees all the very best in achieving a classification system for non-admitted activities that is keeping up with our time.

Yours Sincerely

Micheal Kundukulam

Hazelbrook - 2779

The non-admitted care landscape in Australia

Health system trends

While acknowledging the statements made in this paragraph are partly true, it is important to note that the redesign of community health services is not consistent across LHN's and the redesign is not always geared to better manage acute hospital community interface. While this is an important change to occur the incentive for this change is not currently available. On the contrary there is enough demand for the services that community health provide in whatever models they currently deploy.

The positive change where better acute community interface is occurring is largely influenced by local innovations either funded through jurisdictions or innovations developed between LHN, PHN, and other agencies including consumers to ensure clinical safety of consumers as acute hospitals are moving to shorter stay models of care. This positive change can be partly attributed to the ABF model and the levers and measures created for PHN to perform in their local boundaries.

In designing a new classification for non-admitted care services IHPA must acknowledge the extremes of acute community interface innovation and all the other stages in between that can be found across the country.

Primary care boundaries with public hospital services.

Managed care models do provide many opportunities for improvements. The new classification will need to direct appropriate models to be delivered as managed care. The clinical outputs that are required to be achieved at acute, community and primary care must be defined for the condition. Existing literature and best practice / guidelines would provide directions on what is required to be undertaken to manage the condition. However the question of who does what as a non-admitted patient remains quite ill-defined in our health system across community health and general practice, creating wider cracks for the consumers to fall through. The LHN's and PHN's must be required to work to determine how this is managed locally. Such local assignment of clinical interventions by services funded under ABF must be considered under the new classification. This is especially important as every general practice is an individual business and every general practice has varying levels of patient demographics and patterns of morbidity, resource, infrastructure, and business models. Similarly every community health service is at varying stage of maturity to address disease specific care including community health models that exist without medical governance. The focus of funding must be to achieve the clinical outputs for the consumer and direct funds to those services that address the existing gap. It must be noted the capacity of local primary care services must be constantly reviewed to ensure that funding is not directed to no-admitted services creating competition in the market between community health services and general practice.

Chronic disease models.

The common characteristics of best practice chronic disease models and examples are well noted in the paper. As Health Care Homes have just begun their journey and would take quite a few years to mature while constantly adapting to the changing political, financial and morbidity landscape in our country, the ANACC system will need to support the process of

identification, care coordination, support of care givers and foster integrated medical record. Care coordination especially takes time and as the saying goes, care coordination reveals rather than resolves conditions and meaningful care coordination takes time. Funding must be geared towards complimenting the work of Health Care Homes where records must clearly define which service is undertaking the function of care coordination and which service is providing specific intervention. Directing non admitted funds to services only for such functions that is a gap in the local region fosters the local region to build better health care neighbourhoods with clarity of functions and role delineation between non-admitted and general practice for each consumer.

Digital transformation

The use of My Health Record (MHR) is a significant first step towards creating a meaningful EHR. However it appears that the ability of MHR to accept and host atomic data and for the EMR's to provide SNOWMED CT is still a human generation away. Real-time feed of current clinical diagnosis, pathology, radiology, diagnostics, and accountability/responsibility of care is critically required to be made available for meaningful integration and continuity of care across admitted and non-admitted care. Living in the context of MHR this real-time atomic collation to provide a summary of care seems unrealistic in the short term in the current environment.

To achieve real time shared care planning especially for people with chronic conditions and vulnerable population, the path taken through the Health Care Home trial appears to be a logical step to follow. Jurisdictions must be supported with funding to develop and release functional specifications to the market for the market to develop a shared care planning tool. The tool that is dynamically led by the manager of care must be able to be initiated from existing EMR's. It must seamlessly integrate information from eMR of publically funded services including general practice and feed into EHR and PHR's.

Consultation Questions

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

Yes.

Non admitted care classification (ANACC) may be classified into multiple categories and

a. Under each category include integrated care as an activity.
   Example of integrated care activities are
   - Video consulting/teleconference with general practitioners with patient present
   - Video consulting/ teleconference with medical workforce for medical input at the point of care such as home environment,
   - transfer of care teleconference as a participant to a discharge teleconference from the hospital,
   - case conference with the GP as a participant or as an organiser
   - participant or organiser of a multidisciplinary case conference including a medical doctor from acute or a general practitioner present
   - sending discharge documentation to a GP

b. In addition, one of the category must be to deliver integrated care.

ANACC must direct the service provision to address gaps in the health care system of the local region. This implies that funding is provided to undertake only those integration activities that are not already available in the region. For example

- Care coordination: consumers with chronic conditions and vulnerable population who are referred to access ANACC service must be identified if they are already participating in a Health Care Home. If they are, consumers must be excluded from receiving care coordination through ANACC. However ANACC must allow for service provision to be provided as part of the Health Care Home team if invited to do so.

  For consumers who are not part of the Health Care Home, contact must be established by ANACC services with the general practice including Aboriginal Community Controlled Organisations to determine and agree on who would provide care coordination. Only in the absence of care coordination resource locally must ANACC fund care coordination for consumers who are identified as eligible, using a risk matrix score. Existing tools such as the western HARP tool, or the Ccops tool used by NSW Health and the ones used by Health Care Homes may be considered for precedence.

    - Bundled payments: ANACC payments must allow for bundled payments for services to achieve outcomes for those consumers who are part of a general practice that does not have the resources to undertake care coordination. Outcomes must be in aligned to the outcomes set out in the Health Care Home model.

- Hospital in the Home and aged care facilities (HITH): Considering the increasing evidence of HITH, ANACC must foster HITH by increasing funding for medically led HITH activities. This must be limited to providing
    - Post-acute short term high frequency care as an intermediate service that integrates acute with community based services including general practice.
    - Being a first responder to an exacerbating condition in the community. It must allow for the use of wearable devices by the consumer to monitor conditions remotely by HITH. This will be in addition to providing consultation and advice to community based clinicians and responding to exacerbating conditions by navigating the consumer to the right care, at the right time.

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. ANACC must provide for funding local newer models of care.

   It is increasingly evident that there are significant innovations at the local area to address the pressures in health from the lens of the health system of care. while many examples can be seen of the intent or the early stages of the use of consumer outcomes and experience measures, it would be a fair statement to make that as a nation we are still in the infancy of designing and measuring the performance of a health service based on consumer experience and outcome measures as one of the

key performance indicator. ANACC must include consumer experience and outcome measures as measure of performance to trigger funding.

ANACC must provide a narrative on what it is trying to achieve and be clear to the jursidictions on the goals of the ANACC. This may very well be the quadruple aim of improving the individual experience of care; improving the health of populations; reducing the per capita cost of healthcare and improving the provider well-being or the goals may be a part thereof. ANACC must allow for newer models of care that meets the objectives of achieving the above goals. Some examples of objectives are for the models to ensure minimal clinical variation across all population and disease groups; to ensure timely access to care especially for priority population; and to ensure continuity of care. Priority must indeed be provided to the cohort of population that is at the highest risk as identified by the evidence based local population health analysis developed between Primary Health Network and Local Health Network. It is critical to ensure that ANACC funded models of care do not compete with existing services in the local region and that every activity is linked to Individual Health Identifier (IHI).

Funding must evolve from funding for hours of activities and block funding services, to funding outputs of the newer models at a national efficient price providing for appropriate adjustments and set up costs. It must accommodate for delivering outputs which is partly achieved through Medicare and partly through ANACC against a shared care plan as the evidence of providing a whole package of care against an agreed best practice for an IHI. Additional weightage must be provided to the models of care that use wearable devices, remote monitoring, and existing IT infrastructure such as the video consulting platform available within the COAG funded Healthdirect Australia infrastructure.

Further to which ANACC must also consider bold moves to penalise services if service standards are not met such as longer than accepted waiting times, higher clinical variation against a standard of care or absence/lack of continuity in care.

3. As the type of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes?

ANACC must include provisions to reflect the local efforts to integrate the health system or the lack thereof. It must accommodate for delivering those services where the supply does not meet demand in the local region and trigger disincentives for competing with locally available services or carrying out functions that are funded through other sources including but not limited to MBS, My Aged Care (MAC), and Veterans affairs. The focus of ANACC must be the consumer. It must ensure that the consumer is receiving the outputs as determined by evidence based best practice in a timely manner. Therefore the administrative records against each IHI must in real-time reflect the conditions that are being managed, manager of care, the outputs that are required to be delivered to the consumer against best practice and reflect the assignment of the activities to a local team spread across ANACC, ABF, MBS, PBS, MAC, DVA and other publically funded and public private partnership funded services. Political, financial, geographical and social drivers influence local evolvement of health system of care to meet morbidity and demand pressures to the health

system. As there are variations in each LHN/PHN boundaries of these evolutions ANACC must be flexible enough to accommodate the local evolution and prescriptive enough to ensure the consumer is receiving the outputs in a timely manner.

Creating an appropriate non-admitted care classification

Consultation Question

4. ***The Classification principles have been assigned 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?***

In addition to the draft of classification principles the following must be considered

Clinical meaning (existing)

- Add - Classification must be linked to diagnosis where available. This will enable to measure clinical variations upon integrating non-admitted care classification with other available classifications.

Patient based (existing)

- Add - Should be able to be applied to Patient Experience and Outcome Measures

Localisation (Addition)

- The classification must reflect the absence or lack of available intervention in the local region. Such intervention may to be deliver ANACC service against the best practice for a diagnosis or to deliver an intervention in isolation where diagnosis is not available.

Proposed classification concepts and variables

5.1 Unit of count/activity

In the current evolving landscape of our health system of care and the proposed development of ANACC it is vital to determine the gap that ANACC is trying to address. The vision and the narrative to develop ANACC would influence the definition of and the use of Service event and Episode of Care. It is recommended that ANACC must be considered in the context of other funding including but not limited to MBS, Health Care Homes bundled payment and My Aged Care.

Consultation question

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?***

Scenario one (to be read with the above paragraph)

In a scenario where ANACC is considered in isolation, a service event must be defined as:

"..an interaction between one or more health care provider(s) electronically or in person with one-admitted patient, which must contain therapeutic/clinical/health literacy/self-management content and result in a dated entry in the patient's medical record.

The interaction may:

- be for assessment, examination, consultation, treatment, education and/or health system navigation.
- be provided on behalf of the patient during a non-admitted multidisciplinary case conference (MDCC) or discharge teleconference or co-ordination of care or consultation between medical and other clinicians where the patient is not present
- be provided by the patient in their own environment without the presence of a healthcare provider."

Scenario two: (where ANACC is considered accounting for including and not limited to MBS, bundled payments for Healthcare Homes and My Health Care system.)

In this scenario classification includes Service event and Episode of care. Then Service event is defined as

"..an interaction between one or more health care provider(s) electronically or in person with one-admitted patient, which must contain therapeutic/clinical/ content and result in a dated entry in the patient's medical record.

The interaction may:

- be for assessment, examination, consultation, treatment and/or education
- be provided on behalf of the patient participating in a non-admitted multidisciplinary case conference (MDCC) or discharge teleconference or consultation between medical and other clinicians where the patient is not present
- be provided by the patient in their own environment without the presence of a healthcare provider."

Episode of care will then include all forms or care including care coordination, health system navigation, self-management health literacy and periods of treatment to achieve a set of outcomes in a defined period.

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, it is important to consider episode as a unit of count.

Episode of care must be provided

- Where there is a diagnosis of chronic or persistent conditions and the consumer is not registered as receiving care under Health Care Home. The outcomes to be achieved for people with chronic or persistent conditions must be achieved with evidence of it being in partnership with general practitioner and consistent with the outcomes that are designed to be achieved under HealthCare Home
- For palliative, rehabilitation of care, antenatal care

- Hospital in the Home like services which provides post-acute short term high frequency of care in the home environment or in aged care facilities.
- Procedures or services such as cancer care, chemotherapy, radiation oncology,
- Period of care for people that require specialist advice with diagnostic certainty or period of care where a temporary intervention is required before a permanent intervention. For example providing assisted peritoneal dialysis provided at home while patients wait for permanent arteriovenous graft or arteriovenous fistula procedure to be completed and healed.
- Period of care before elective surgery
- Care provided by integrated multidisciplinary care such as post organ transplantation

5.2. Diagnosis-type and intervention-type variables

Consultation questions

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. In addition and importantly the chronic disease classification must require the provider to clarify the care partnership with the general practitioner to mitigate duplication and competition and foster health care neighbourhoods.

8. ***What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?***
No comment. Jurisdictions representatives would be best placed to answer. In the interest of consumers the implementation must not exceed three years.

9. **What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?**
ANACC must allow for both diagnosis type and presenting problem. Non-admitted service event or episode of care that is provided to a consumer as a post-acute intervention, awaiting acute intervention such as an elective surgery or care coordination, must always require a diagnosis type and linked to ICD-10-AM. Presenting problem can be linked to a presentation that is not linked to any of the above presentation.

10. **Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'?**
Yes and agree. However it is important to note the ANACC system must require the recording of mandatory data sets before assigning the intervention as a presenting problem. Mandatory data sets include the multiple variables discussed such as diagnosis type and presenting problem; service event, episode of care and mode of care; complexity variable; patient experience; general practice and or Health Care Home variable.

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?***

Agree.

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 addition to the proposed, Priority Population as defined by AIHW must be included especially population from low socio economic statistical local area as identified by low SEIFA scores. While this variable in itself will not be a driving factor, socio, economic, geographic and cultural factors related to priority population influence the resource required to provide interventions and achieve the same clinical outcome in comparison with the population that are not identified in the priority population.