NSW GOVERNMENT | Health

H18/11766-4

Mr James Downie
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Dear Mr James Downie

Thank you for the opportunity to provide comment on the Australian Non-Admitted Care Classification (ANACC) Development Stakeholder Consultation Paper, February to April 2018.

Please find attached correspondence regarding the NSW Health 'Australian Non-Admitted Care Classification Development Stakeholder Consultation Paper' response.

The correspondence addresses the 12 questions required by the ANACC consultation paper.

If there is anything further you would like to discuss regarding the NSW consultation response please do not hesitate to contact Susan Dunn, Manager, Stakeholder Engagement and Clinical Variation, Activity Based Management on 9391 9405 or at sdunn@doh.health.nsw.gov.au.

Yours sincerely

16.4.18

Dr Nigel Lyons
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Att: NSW Health ANACC Response

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Australian Non-Admitted Care Classification Development Stakeholder Consultation

NSW HEALTH SUBMISSION

This submission provides comment on the Independent Hospital Pricing Authority's (IHPA's) stakeholder consultation paper on the development of the Australian Non-Admitted Care Classification (ANACC).

NSW congratulates IHPA on a consultation paper that demonstrates that IHPA is attentive to the concerns of the jurisdictions. Whilst the paper offers little in the way of understanding where the classification is currently at, it does provide insights not previously included in public consultation papers by IHPA, i.e. need to find a way of linking classifications across streams, planning to classify all care delivered not just that funded by ABF and lastly a consideration of how the system can work with other commonwealth system such as MBS.

Integrated care is a new paradigm in health care. It reflects the need for communities, government, health and social care providers to work together to improve the health status and equity for users of NSW Health. The non-admitted classification needs to be able to reflect this work and acknowledge all the different providers and negotiations required with or without the patient present.

Consultation question:

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

NSW Health is investing in new, innovative models of integrated care to transform the health system to routinely deliver person-centered, seamless, efficient and effective care, particularly for people with complex, long term conditions.

NSW Health requests IHPA clarify the definition and scope of health care settings referred to in this consultation paper. If a setting includes primary care through GP's, the considerations required and complexity of any classification would have a significant impact on the considerations required for classification development.

NSW agrees in principle that the new classification for non-admitted care should support the delivery of integrated care between health care settings, however has concerns for the ability of the new classification to adequately provide for the enormous changes foreshadowed for health care developments and service delivery in the non-inpatient hospital setting. There are many aspects of integrated care in addition to the main stays of integrated care, i.e. care navigation, health coaching and care coordination. The ANACC classification will need to ensure that integrated care activities are discretely identified and subsequently funded, without making the classification a workload tool. This is further challenged by the volume of multidisciplinary providers. Interfacing and capturing the relationship of different care providers and settings for a patient will be crucial to the acceptance of the classification by clinicians.

The use of non-clinical support personnel by health services is increasingly being shown to be a safe and effective way of helping maintain patients in out of hospital care. Currently, a service event

cannot be triggered by such staff. The new ANACC needs to review the role that non-clinical support personnel play in partnership with clinicians, in preventing hospitalisation. Already, changes in models of care are moving patients out of long term hospital care into community care, and the care provided is split between both clinical and non-clinical staff.

Capturing a patient's journey provides an understanding of the care requirements for those who experience chronic or complex health needs, thereby identifying the resource consumption by the providers of health care. The ANACC needs to apply to any clinical or service delivery model of care while remaining agnostic as to the setting/location the care has been provided in.

The ANACC should reflect the care provided and should not influence or drive the provision of any models of care. The ANACC should support appropriate clinical care provided and be shaped around the characteristics of existing or emerging models of care, both within or across health care settings.

Interfacing integrated care across different health care settings could be accomplished in a number of ways, depending on which concept of count IHPA include, such as:

- Integrated care classes or modalities.
- Price weight adjustments for flagged integrated care activities.
- Price weight adjustments linked to recent encounters with the health service.
- Identification of care coordinators or navigators as providers where no patient contact exists.

Consultation question:

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

NSW Health agrees the new classification for non-admitted care services should account for and adapt to newer models of care and technology. As stated earlier, NSW has concerns for the ability of the new classification to adequately provide for the enormous changes foreshadowed for health care developments and service delivery in the non-inpatient hospital setting.

In the current Tier 2 classification, new models of care in the non-admitted and community setting are often de-incentivised, both in the price weights attached to the clinic and in the length of time it takes for the classification and appropriate price weight allocation to occur. The classification should be structurally flexible to allow for periodic interim modifications to occur as new models of care emerge. Equally, succinct costing studies may be needed to provide guidance for price weight setting, as opposed to waiting until the National Hospital Cost Data Collection has caught up with the introduction of emerging models of care. This is also the case for including new technologies into the classification. Innovation grants may be required in initial stages of technology migration where the price does not cover use of technology, either for direct clinical use or for data captured in the electronic medical record (EMR).

In NSW, Leading Better Value Care is a strategic initiative to manage chronic disease. The model involves multiple elements of care and requires the management of patients within different care settings. It is a non-linear process, and the ANACC requires flexibility to manage and deliver both the clinical care and the care navigation of such patients. One approach is to test new models of care, identify best practice pathways and cost these pathways in preparation for funding, rather than apply a 'best fit' solution.

Identifying technology in the ANACC includes capture of technology being used, recognising the new technology as an appropriate service delivery, and/or capturing and reflecting the costs for pricing in a timely manner. The current service delivery mode within the non-admitted National Minimum Data Set needs to be further inclusive of technologies.

It is important for the ANACC to recognise and identify services/treatments provided in areas with and without the presence of a healthcare provider, e.g. home delivered care and remote home monitoring. It is equally important to capture and collect clinical related data, as well as measuring costs associated with this method of service delivery. A number of care programs now include the increased use of technology to deliver care, with some examples offered below:

- post-surgery rehabilitation programs where exercises are done at home with clinician support via videolink.
- post discharge phone calls to ensure patient and carer/s understand and are following a discharge plan, and provide additional clinical direction as needed.
- programs designed to keep people living in their own home, such as Tai Chi for arthritis exercise groups via videolink.
- oral health promotion tooth brushing applications.

Consultation question:

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?

In the longer term, an ability to classify and then fund end-to-end care for patients rather than segregating funding into streams would better support holistic health management. Consideration should be given when designing the ANACC to how it would interact with other care stream service delivery and funding in the future.

Interfacing with care models provides flexibility to capture activity and remove boundaries between different streams of care, especially where the episode of care overlaps from the patient perspective, e.g. bundling pre-admission/perioperative and post-operative clinic visits with surgical admissions.

Flexibility within the ANACC should provide options within the classification to appropriately stratify patients who potentially have multiple care pathways for different types of treatment journeys. This highlights the requirement for the classification to be absolutely 'setting agonistic'.

A further consideration in flexibility could be for the ANACC to provide incentives for newer and more appropriate models of care. While most current classifications are retrospective in nature as to the appropriate resourcing of the service (i.e. price often lags three to five years behind service delivery cost), the ANACC should develop a mechanism to overcome this barrier to innovation. It is recommended that IHPA consider removing any bias attached to settings for private revenue which is applicable in one setting compared to another. For example, admitted day only rehabilitation receives a rebate however non-admitted rehabilitation does not.

The ANACC can only meet the challenges of working across all care streams by continued implementation of the EMR across all sectors, including the IHI or equivalent, that is of a robust quality level to be dependable. NSW believes there is room for improvement in the quality of the IHI and ways in which duplicates are managed. NSW supports standardisation of terminology and also investigating less traditional ways of coding patient records. NSW recommends that IHPA invest in natural language algorithm that meets the coding requirements of the ANACC. Despite the speed of

development in this area, it will take health information technology (IT) systems a significant period of time to embed the technology into NSW systems. IHPA need to factor this into any time frames for the move to ANACC or at least all elements of ANACC.

Consultation question:

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?

NSW Health agrees with the current classification principles and the majority of the key considerations in designing the ANACC.

NSW agrees that all services are to be classified and not just those considered "in-scope" for Commonwealth funding. From a NSW perspective, excluding the MBS component raises further significant issues for NSW for rights of private practice. This is a significant issue that will need to be discussed with IHPA. The use of private health insurance and the rights of private practice within ANACC should be in line with those applied in acute services.

To guide and support development of the future ANACC requires further development work, as noted below:

- Resource use homogeneity
    - It may be a challenge to maintain stable resource homogeneity in an environment of evolving modalities such as new technologies. Recognising service delivery models and technology changes often results in a redistribution of resource utilisation over time, for example those services moving from an admitted to a non-admitted basis.
- Patient-based
    - IHPA should consider the wording of the patient based principle as data elements are developed, to reflect attributes of care rather than being the attributes themselves.
- Utility beyond activity based funding
    - The sentence "...other than funding" should be reconsidered as this presupposes funding as the basis for the classification, and should include funding as one of the listed purposes, not the basis.
    - Include clinical research to the list of purposes.

Additional Comments

The document states in section 4.3 that "While non-admitted patients may move in and out of different care types they cannot be synchronously reported, providing a barrier for integration."

This is an artefact of the reporting rules and does not represent a barrier for care integration. The care and treatment should proceed with the classifications data capture and reporting rules adaptive to the patient service requirements.

The consultation paper in section 4.3 confuses the classification of patients, care and use of classified data for multiple purposes with the administrative functions of pricing and funding. Costing and pricing (including subsequent funding) are flow on functions to the collection and classification of patient level data, which can then be used for multiple purposes.

Failure to recognise this distinction will limit the ANACC's ability to interact or align with other classifications, e.g. IDC-10-AM as the base classification (not the 'derived' classification of AR-DRG).

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?

NSW Health agrees IHPA should continue to use the service event as the primary unit of count for the ANACC, and agrees with the proposed revised definition of a service event in the short term. NSW recommends the definition of service event be improved by amending or clarifying the following:

- "be for assessment, examination, consultation, treatment and/or education" pg. 26. This is not required as it limits the definition of what a service event may be with the effect of restricting future potential hospital avoidance initiatives. NSW also recommends IHPA expand the definition to include additional interactions which are beneficial to the patient, but may occur when the patient is not present, such as Therapeutic Goods Administration submissions, guardianship submissions, integrated care activities of care co-ordination and navigation.
- "MDCC" – contradicts the definition that it is an interaction between provider/s and a patient. The definition requires further review if included.
- "Patient in their own environment without the presence of healthcare provider" contradicts the definition of an interaction between one or more health care providers with one non-admitted patient. The definition requires further review if included.

Consultation question:

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?

NSW agrees in principle that consideration needs to be given to a different measure of count in the longer term and as information technology (IT) systems can be adapted. NSW Health requires further development work and testing before agreeing to this change of count in the new ANACC. Pilot testing is required with various conditions/services to ensure it is an appropriate unit of count. Without testing service provisions first, funding could be compromised for different patient cohort groups.

NSW would like IHPA to consider including both service event and episode of care as counting measures. Acknowledging that the inclusion of both measures will increase the complexity of data collection and reporting, NSW suggests that the episode based unit of count is only introduced when it reflects a significant cost/benefit value for the system.

A dual counting system would allow a more complete classification considering the vast differences in non-admitted patient types, complexity of patients, varying times needed and interventions undertaken. More complex multi-system, comorbidity patients would be more likely to have episodes of care. Procedures or short groupings of encounters could be counted by service event. Specific conditions with well-defined, evidence-based clinical pathways would be suitable for episodes of care, e.g. cardiology rehabilitation and bundled ambulatory cancer.

IHPA would need to clearly distinguish between episodes of care and bundling of service events.

Consultation question:

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?

Within the NSW consultation responses there were equal and opposing views on this. Whilst people believe that the classification should be sophisticated enough to classify and support chronic disease management, on the other hand there are reservations of its practical ability to do so.

Consultation question:

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

Time frame requirements are dependent on a number of factors which are yet to be addressed. Specifically:

- Extent of infrastructure and software application changes required.
- Extent of integration with other classifications and data collection processes.
- Ability to incorporate or extend current committed work programs.
- Education and training requirements.
- Implementation of change management program.

NSW envisage that the time scale would be at least three to five years, considering IT have work plans that span the next five years and that changes discussed here having not yet been considered. This is based on past experience and implementation of the Australian Mental Health Care Classification.

Consultation question:

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

The consultation paper has considered the benefits and challenges involved in including a diagnosis type variable in a patient centric classification. NSW supports this as the first step to a patient level classification whilst recognising the challenges it brings.

Including a diagnosis-type variable with the expectation that clinicians will 'code' it requires well defined categories that are clinically relatable and easily searchable amongst the other selections available. Whilst a diagnosis variable is medically aligned, other factors also need to be considered, such as additional services needed; activities and resources consumed; patient assessment; social situation; cognitive and physical functioning. These change the dynamics of care provision and resource consumption and funding required.

NSW clinicians have raised concerns about how their individual diagnosis at an occasion of service level will be captured and grouped if multiple providers in the service event all enter different diagnosis or presenting problems. The ANACC will need to give consideration to how the principal diagnosis/presenting problem will be selected in a non-coder environment.

Clinical systems must also be upgraded to allow this data capture to occur smoothly to minimise clinical risk and increase likelihood of complete data capture. However, alternatives to burdening clinicians

with additional data input will need to be investigated and invested in. Technology that supports machine learning with natural language algorithms will need to be considered to extract the required data elements from already entered notes. This will be at significant cost to jurisdictions. Significant change management strategies will need to be in place during implementation.

Consultation question:

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

NSW Health agrees that 'presenting problem' could be used as the diagnosis type variable. 'Presenting problem' recognises a broader approach than diagnosis within the non-admitted patient setting. Given the divergence of interactions, the often shorter interactions, the non-medical basis of many services and that many services will be provided without a confirmed diagnosis, 'presenting problem' has many advantages for this setting.

Often clinicians may not know exactly what is wrong in the first consultation, and diagnosis is only possible once relevant assessments and tests are undertaken. This is demonstrated in the geriatric population. 'Presenting problem' is often vague and undifferentiated. Diagnosing requires a more complex assessment and diagnostic process. Including 'presenting problem' as a variable more accurately reflects the work involved in caring for a patient.

Whilst the 'presenting problem' definition is a good start, NSW Health does not agree with the proposed definition of 'presenting problem' in its current form. Issues to consider in the review of the definition include:

- The term itself should not be used in its own definition (problem). Alternate: condition.
- The presenting problem may not be determined by the clinician first assessing the patient.
- May be determined by other than a clinician from the health service providing the service, e.g. the 'referral issue' may be used for initial interactions before more investigation/analysis of a patient's condition is undertaken.

IHPA will need to ensure that free text is not part of the process to select a presenting problem.

Consultation question:

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?

NSW believes the proposed list is a robust start to its development, however requires significantly more clinician input, consultation and testing for further development. As acknowledged by IHPA, the proposed list is a similar design to the hierarchical relationship between MDC, AR-DRGS and ICD1-10-AM/ARCHI codes to enable capture of a complete patent journey.

NSW in principle supports many of the refinements highlighted within the ANACC consultation paper, including the need to include hospital acquired complications, the need to incorporate age, comorbidities, multi-disciplinary, provider type (including non-clinical health support workers) and multiple follow up visits.

In addition, IHPA need to consider components of the NSW Leading Better Value Care model of care and integrated care models of care.

Areas that appear to be missing or need strengthening in the list include:

- MDC 03 Diseases and Disorders of the Ear, Nose , Mouth and Throat
    - Dental caries and injury.
- MDC 05 Diseases and Disorders of the Circulatory System
    - Acute myocardial infarction could be further categorised as STEMI/non-STEMI.
- MDC 13 Diseases and Disorders of the Female Reproductive System
    - Suggest female reproduction management be separated out as a presenting problem/diagnosis type group.
- MDC 15 Newborns and Other Neonates
    - The classification of antenatal visits should be able to distinguish what qualifies for a 'first antenatal visit' (for each pregnancy).
- MDC 19 Mental Diseases and Disorders – NSW seeks clarification as to the reasoning for inclusion here and not in the AMHCC, or whether this is for non-specialised services?
- MDC 20 Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders
    - Alcohol and other drug problem groups could be improved substantially.
    - Gambling problems would fit better within MDC19 rather than MDC20.
    - Intervention groupings should align with the relevant national data standard.
    - NSW suggests the following groupings (or similar) be added.

Proposed presenting problem /diagnosis-type groupings	**Proposed intervention-type groupings**
Intoxication and withdrawal:	Withdrawal management (detoxification)
- Alcohol	Counselling
- Methamphetamine	Rehabilitation
- Other amphetamines	Pharmacotherapy
- Other stimulants and hallucinogens	Support and case management only
- Heroin	Information and education only
- Other opioids	Assessment only
- Benzodiazepines	Other
- Cannabinoids	
- Other drugs	
Use and dependence:	
- Alcohol	
- Methamphetamine	
- Other amphetamines	
- Other stimulants and hallucinogens	
- Heroin	
- Other opioids	

- Benzodiazepines	
- Cannabinoids	
- Tobacco and nicotine	
- Other drugs	

- MDC 22 Burns
  - The terminology used to describe depth/severity of burn, for example the *'Degrees of burn injury'* is out dated and not used in Australia.
  - The column 'Proposed intervention-type groupings' below provides suggested alternate terminology to more accurately reflect complexity injury and interventions.

Proposed presenting problem/diagnosis-type groupings	**Proposed intervention-type groupings**
Burn epidermal (erythema, sunburn)	Wound management (burn dressings and other dressings)
Burn, superficial dermal, mid dermal (heals with conservative management - non-surgical) simple (one body region)	Initial post-operative (skin graft/reconstructive surgery) dressing change +/- suture removal
Burn, superficial dermal, mid dermal (heals with conservative management - non-surgical) complex (multiple body regions or complex region, e.g. hand)	Scar management (pressure garments, splinting, exercise, scar softening techniques)
Burn, deep dermal/full thickness (commonly post-acute care discharge short length of stay (LOS) simple (one body region)	
Burn, deep dermal/full thickness (commonly post-acute care discharge long LOS) complex (multiple body regions or complex region, e.g. hand)	
Other burns	

Prevention is an important aspect in improving health outcomes for individual patients, population health and reducing overall healthcare costs, and would be a valid component of non-admitted care, for example smoking cessation advice, routine follow-up appointments, screening mammogram and vaccination. IHPA needs to develop a complete and comprehensive classification with a view to preventing hospitalisation in the future. The list presented so far is heavily based on a medical management and not on holistic health.

Consultation question:

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?

NSW Health agrees with the complexity variables presented in section 5.3.

The following variables are provided for consideration:

- Aboriginality.
- Gender.
- Urgency of treatment. This impacts both complexity and resource intensity.
- Comorbidities account for some complexity variables. Patients with chronic condition and complex psychosocial situation are likely to return for multiple visits for the same diagnosis. Social determinants are an important inclusion variable. It ensures appropriate care coordination is provided in an integrated care setting.
- Age requires further distinction between paediatrics and adults. Paediatrics requires further granularity, for example using an age group of 0-14 or even 0-4 is insufficient for NSW paediatric hospitals, as the models of care for babies would be very different to infants and teenagers. In conjunction with paediatrics, the current approach of using the Charlson Index as the primary measure of comorbidity burden is not as relevant in paediatrics due to the list of conditions considered in the original study, which focused entirely on adult populations. Alternative comorbidity indexes such as those proposed by Derek Tai et al (Arch Pediatr Adolesc Med. 2006;160(3):293-299. doi:10.1001/archpedi.160.3.293) are more applicable for a paediatric population.
- Impact on telemonitoring for older people or CALD populations with English as a second language.

End of response