Australian Non-Admitted Care Classification Public Consultation

Healthcare Purchasing and System Performance

Background

The Independent Hospital Pricing Authority (IHPA) is seeking feedback from stakeholders on the Australian Non-Admitted Care Classification (ANACC) Public Consultation Paper (the Consultation Paper), which was released on 9 February for public feedback.

IHPA is developing the ANACC to replace the current Tier 2 Non-Admitted Services Classification. The ANACC aims to provide a patient-centric model that will enhance data capture and have application beyond Activity Based Funding (ABF), such as informing policy. The development of the ANACC builds on a significant program of work to refine the ABF framework for non-admitted care.

The Consultation Paper seeks stakeholder's views on the potential characteristics of the ANACC, including the patient condition and intervention characteristics that will form the key concepts in the classification hierarchy. The paper also describes the changing non-admitted care landscape in Australia. Issues considered include: Australia's demographic challenges and how this is impacting healthcare and service delivery; changes to the types of services provided in the admitted, non-admitted and primary care settings; innovations in models of care including chronic disease management; and the impacts of digital transformation on data reporting and patient services.

Consultation

The Department of Health, Queensland Government (the Department) has consulted with stakeholders both within the Department as well as Hospital and Health Services (HHS). Stakeholders were also encouraged to respond directly to IHPA. Note that feedback in this document is from the Department, unless otherwise identified as being from a specific Queensland stakeholder.

Overall Comments

Stakeholder feedback was received from the following:

- Central West HHS,
- Gold Coast HHS,
- Metro South HHS,
- Sunshine Coast HHS,
- Townsville HHS,
- West Moreton HHS,
- Wide Bay HHS,
- Allied Health Professions' Office of Queensland and Office of Chief Dental Officer (both within Clinical Executive Division),

- eHealth Queensland (Digital Strategic Branch),
- Healthcare Purchasing and Funding Branch (Healthcare Purchasing and System Performance Division), and Statistical Services Branch and System Planning Branch (both within Strategy, Policy and Planning Division).

Queensland stakeholders support the development of the ANACC and welcome the introduction of an evidenced-based patient-centric classification system for non-admitted services. It is acknowledged that the existing Tier 2 Non-Admitted Services Classification (Tier 2) is not ideal for the purposes of ABF research and the broader application to policy objectives in the longer term.

The Department supports IHPA's commitment to move from a provider centric classification to one that is patient-centric and not influenced by provider type (i.e. medical, nursing, allied health) and / or setting (e.g. outpatient versus home). This will enable new models of care, which do not influence the provision of care by one type of practitioner over another or one setting over another but enable timely care to be provided by the most appropriate practitioners in the most appropriate setting. The ANACC must appreciate preventative care and screening programs and be adaptable to new technologies and models of care. To ensure ongoing relevance the classification must recognise evolving models of care rather that building a structure based on the current state.

A pre-implementation pilot is highly recommended to ensure the ANACC achieves its anticipated outcomes. The pilot would enable a full assessment of the resources and costs associated with the collection.

Prior to full operationalisation, it is crucial that the ANACC be shadowed with the Tier 2 classification to measure variances and establish baseline data to facilitate performance analysis. A data quality and evaluation framework will enable continual improvement to not only the classification but also service provision.

A key strategic priority for Queensland is the delivery of value-based healthcare. Queensland Health is developing an approach to deliver what really matters to patients and the Queensland community and maximising the value of our health system.

The Department notes that classification principles enunciate that the ANACC will consider best practice, quality and safety and performance reporting. This is congruent with the Queensland direction however it is vital that greater focus be placed on the use of variables within the classification that measure the quality and safety of care received, including the patient's overall satisfaction with the outcome.

A major theme of the Consultation Paper is the importance of building an integrated classification system that supports care delivery across multiple organisations. Section 3.2.1 states that *"the single patient identifier will facilitate the accurate identification of service delivery to patients across settings of care, financial years and hospital establishments, and will support the introduction of innovative funding models and better understanding of service delivery trends."* The establishment of a unique patient identifier is integral to enable provision of care across all health settings, actualise new models of care and develop contemporary funding mechanisms. The Department recognises IHPA's commitment to addressing this reporting deficit and the work currently underway to introduce the Individual Healthcare Identifier in national datasets.

Queensland stakeholders cited a number of concerns with the transition to the ANACC. Although the Consultation Paper states that *"the information to be captured for the purpose of classifying non-admitted care should not require a separate coding workforce and will need to occur using existing capabilities"* Queensland HHSs have expressed reservations whether this goal can be accomplished.

It is anticipated the ability to effectively and efficiently collect diagnosis level information for non-admitted services will be improved by the advent of Electronic Medical Records. It is however a risk to assume the challenges associated with the correct recording and reporting of patient information will be entirely

mitigated with the evolution of digital healthcare. HHSs and other business units with the Department of Health collectively noted that the transition to a patient-based characteristic focussed collection cannot be effectuated in the short term. Existing information systems will need to be upgraded or superseded, and staff educated to support the ANACC. The Department acknowledges and concurs with these concerns. To lessen stakeholder apprehension it is critical IHPA develop a clear timetable that articulates expectations and responsibilities in the development and eventual rollout of the ANACC.

The paper is not clear how the ANACC aligns with the National Health Reform (NHR) agreement or the strategic priorities of the Council of Australian Governments (COAG). At the 9 February 2018 meeting COAG agreed to four strategic priorities:

- improving efficiency and ensuring financial sustainability;
- delivering safe, high-quality care in the right place at the right time;
- prioritising prevention and helping people manage their health across their lifetime; and
- driving best practice and performance using data and research.

COAG have committed to explore these priorities and agreed to implement options to drive down the number of avoidable hospital admissions, including through better-coordinated care. The ANACC must align with, and support, the broader national agenda for healthcare.

Responses to Consultation Questions

2. Introduction

2.2 Classification of non-admitted care patients

Although described in section 3.2 “Digital transformation”, the list of care settings in section 2.2 is not as comprehensive as it could be and does not fully take into account the changing environment of technological advancements in healthcare. The Department recommends the inclusion of telehealth services to the examples provided for non-admitted care settings.

2.4 Project phases

The second development step listed is:

- A statistical data analysis of non-admitted care to identify cost drivers and key data trends (completed).

Queensland stakeholders have raised concerns on the impact of variations in admission protocols between jurisdictions and facilities. In recent years there has been movement in some facilities between services delivered in an admitted or non-admitted environment (such as endoscopies, cardiotocography, chemotherapy, angiography and hyperbaric treatment). The Department recommends that IHPA clearly describe how changes in service delivery settings have been managed in the development of the ANACC.

Classifications also need to be flexible as the healthcare system evolves and payments are made based on the delivery of high quality outcomes. The Department recommends that prior to implementation of the ANACC a thorough pilot study is commissioned to ensure the proposed model will not only drive greater efficiency in healthcare, but also deliver better patient outcomes. It is suggested timeframes in section 2.4 (project phases) be reviewed to enable the roll out and evaluation of pilots to test the classification.

3. The non-admitted care landscape in Australia

3.2.1 Electronic health records (eHR)

The Statistical Services Branch noted that not all individuals will have a national eHR and there should be recognition of this in this section of the document. There is the potential that data will be incomplete because of an individual's choice not to maintain an eHR or the capacity of the individual's ability to manage their national eHR.

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

Queensland stakeholders overwhelmingly agreed that ANACC should support the delivery of integrated care between healthcare settings to enable, and incentivise where appropriate, innovative and improved service models. Healthcare delivery is evolving and contemporary models of care are - and will be spread across various settings - with the outcome of greater homogeneity in care The Allied Health Professions' Office of Queensland and System Planning Branch both commented that it would be beneficial for the ANACC to cross the boundaries of hospital and primary health settings. This would enable true integrated care through information sharing. This is particularly relevant for the management of patients suffering from chronic diseases and may also create opportunities for bundled funding; particularly, with the presence of a unique patient identifier.

The System Planning Branch suggested that case managers and other allied health practitioners be consulted in the development of the ANACC due to the central role these professionals have in healthcare delivery. The branch also noted that the World Health Organisation *Global Strategy and Action Plan on Ageing and Health* provides some excellent insights and should be reviewed as part of the classification development (http://www.who.int/ageing/global-strategy/en/).

eHealth Queensland (Digital Strategy Branch) endorsed the proposal that the ANACC should support integrated care however noted that a non-admitted care model is only a medium term solution. eHealth Queensland suggested that a long term view is needed on how the health system is funded across settings (i.e. primary, secondary and community care). Funding should be focussed on patient outcomes and support integrated care between general practitioner / private practice and public health settings.

eHealth Queensland (Digital Strategy Branch) also noted that data and funding between sectors and providers will need broader consideration to successfully support delivery of integrated care between healthcare setting; including legislation for sharing and disclosing information. The branch commented that a reasonable transition period will be required to enable systems (across all sectors) to be upgraded to capture the necessary metrics.

Gold Coast HHS noted that key requirements for the classification development and subsequent cost modelling are required to more clearly understand patient journeys (and their likely variability) and define the scope of services for a range of conditions including quality and safety details. The HHS noted that an integrated care model must consider:

- current and future equipment and infrastructure (physical and digital) to enable continued efficiency and effectiveness within service model;

- evaluating care delivered including patient clinical outcomes, patient reported experience and identification of high value healthcare; and
- functional, psychological and social components and not medical processes, diagnostics or interventions; collectively considered and not in isolation.

The Department recommends the delivery of interdisciplinary care across the health setting be a priority of the ANACC. To enable this it is essential that the classification be congruous with established clinical taxonomies such as Australian Refined Diagnosis Related Groups (AR-DRGs), International Statistical Classification of Diseases and Related Health Problems Tenth Revision Australian Modification (ICD-10-AM) and Systematized Nomenclature of Medicine - Clinical Terms (SNOMED CT) classifications. This will ensure shared clinical terminology, illness categorisation and criteria for advanced diseases.

The Department also strongly suggests that resources be committed to establish a unique patient identifier across the continuum of care; although a number of jurisdictions are independently working towards this, it should be recognised as an IHPA priority.

A strategic priority for Queensland is advancing value in healthcare. This means making a meaningful difference to people's quality of life by doing the "right" things (i.e. things that will truly benefit individuals), and doing so efficiently so that resources go further and benefit more people. The Department notes that integrated service delivery is an essential part of value-based healthcare and recommends that outcome measures be considered as part of the classification development.

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?

Queensland stakeholders overwhelmingly agreed that the ANACC should account for and adapt to newer models of care and technology. The consensus of respondents was that the classification must consider the evolving nature of healthcare provision and recognise:

- The range of "persons" that could potentially deliver services including medical, allied health, nursing, nurse practitioners, nurse navigators, support staff, patient self-administered and carer administrated.
- All mechanisms that can be used now and into the future to enable patient interactions including e-consultations, telehealth and virtual care via remote technology for ongoing monitoring and rapid identification of deterioration in high risk patients.
- All delivery settings including outpatient departments, community health services, community based clinics in public locations and treatments provided in patient's homes.
- Emerging models of care, including case management of complex and chronic disease and other hospital avoidance programs.

Gold Coast HHS and West Moreton HHS commented that the ANACC needs to consider future improvements in patient information systems and eHRs. A robust classification should enable all health treatments to be captured; thus providing better access for health professionals to treatment details and subsequently improve clinical decision-making. The ANACC must also be agnostic to the data capture system and not dependent on data elements only available in specific applications.

West Moreton HHS also commented that the ANACC should be designed to ensure any changes in treatment technologies can be identified and old delivery methods can be linked to new delivery methods, thus enabling consistency for longitudinal analysis.

eHealth Queensland (Digital Strategy Branch) commented that the ANACC needs to consider hospitals that undertake outpatient services through e-consultations[1] as well as remote monitoring and the use of mobile health. Section 3.1.1 (primary care boundaries with public hospital services) discusses managed care models providing opportunities for improvements in patient care and the difficulties for data and classification systems, which remain focused on traditional care; however, there is limited discussion on options to address this issue. Although the consultation paper describes aligning terminology with other classifications so patients can be managed across care, without the underlying systems supporting interoperability and data being atomised this will be difficult to achieve.

The shift from a provider centric classification system to a patient-centric system should facilitate the implementation of new models of care, which do not influence the provision care by one type of practitioner over another, or one setting over another but enable timely care to be provided by the most appropriate practitioner in the most appropriate setting. The Department recommends that the ANACC be flexible for newer models of care and provide benefits to practitioners to enable service delivery re-design for better patient outcomes. It is also crucial that the ANACC be adaptable to new technologies to ensure ongoing relevance. IHPA needs to be cognisant to develop a classification that recognises evolving models of care, rather than building a framework based on the current state.

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?

As noted in the response to consultation question one, Queensland stakeholders expect the ANACC to enable delivery of integrated care across healthcare settings. Based on Queensland stakeholder feedback, the Department notes the following key enablers to support this initiative:

- The development of integrated electronic medical records that have the ability to link with data in non-ABF settings, for instance primary healthcare settings.
- Identified patient pathways and variations with flexibility to adapt as models evolve at different rates in different places.
- Recognition of capacity of community services to deliver hospital avoidance strategies.
- A defined scope of services for conditions that are independent of the place or person who provided them;
- Agreement on evidence based pathways to ensure effective and value based healthcare.
- National and state wide advisory groups consisting of a broad selection of key stakeholders meeting on a regular basis.
- Collection of more detailed information regarding the patient's presenting condition and interventions provided.

[1] An **e-consultation** is a personal interaction between patient and clinician initiated by digital means.

- Scanning new and emerging / changing models of care especially those that will be based on the future use of enhanced technology platforms and provide information of where greatest value / best patient outcomes have been achieved.
- Increased focus on patient outcomes and not just input variables.
- The reporting of diagnostic non-admitted data needs to be considered. Whilst information may be collected at the point of care, in the current non-admitted classification, it is unfunded and reported in isolation to the consultation that initiated the diagnostic intervention.
- Price equity between delivery settings to ensure funding is not a factor in model of care decisions. A number of interventions are now provided in a non-admitted capacity and specific cost components need to be considered to make sure organisations are adequately reimbursed for services rendered (for example prosthetic costs for non-admitted percutaneous transluminal coronary angioplasty (PTCA) and permanent pacemaker (PPM) treatments).
- Alignment of principles and guidelines between classifications: for example, clinical coding standards prescribe coding protocol for specific conditions which must be treated in an admitted setting; it is important that these directives are consistent between classifications to provide robust and congruous frameworks.

The Department supports IHPA's commitment to the ANACC being patient centred as opposed to clinician or setting dependant. Although not specifically related to the ANACC, the Department reiterates the previously mentioned recommendation that resources be committed to establish a unique patient identifier across the continuum of care. Provision of care across all health settings cannot be achieved in the absence of this attribute.

4. Creating an appropriate non-admitted care classification

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 the ANACC?

Queensland stakeholders collectively agreed with the proposed classification principles. Following is a summary of comments from Queensland stakeholders regarding the principles:

- Statistical Services Branch (SSB) suggested the sub-principle beneath the classification principle *"simple and transparent",* be updated to *"assignment of cases to classes should occur thought a process that is transparent and able to be understood by clinicians, health service managers and other users of the data"* to recognise that other consumers need to be able to understand and interpret the data.
- SSB also suggested that an additional sub-principle be added to the classification principle *"administrative and operational feasibility"* stating that the classification will recognise attributes unique to individual facilities including challenges associated with care delivery in rural and remote settings as rurality can affect patient's access to clinicians, the capacity to refer patients to other services and the scope of services available.
- SSB commented that interoperability should be considered in regards to the number of classifications being used across the different care settings; specific elements include data and systems, maintenance and workforce issues.

- Gold Coast HHS noted that the sub-principle *"estimates of resource use within classes should be stable over time"* (*"resource use homogeneity"* classification principle) may be challenging to achieve due to rapid evolution in models of care and the unknown future potential of digital enhancements and technology.
- eHealth (Digital Strategy Branch) commented that the classification principles should clearly articulate that the new classification be developed to support funding to improve clinical outcomes and offer incentives to keep patients in the most cost effective setting.
- System Planning Branch supported the principle that the ANACC should be applicable to different models and / or settings of care (*"comprehensive, mutually exclusive and consistent"* classification principle). The branch reiterated the Department's previous recommendation (consultation question one) that the ANACC be aligned to the AR-DRG or ICD-10-AM classification systems; as such, it was noted that the Urgency Related Group (URG), Urgency Disposition Group (UDG), Australian National Subacute and Non-Acute Patient (AN-SNAP) and Global Burden of Disease classifications could be considered. The branch also suggested that the International Statistical Classification of Diseases and Related Health Problems, Eleventh Revision (Draft) (ICD-11) classification be reviewed when released to assess if it is appropriate to alienate the ANACC to the ICD-11.
- System Planning Branch also noted that the data gathered for the ANACC could be very useful for researchers and planners to better understand current and changing health patterns. The branch suggested that researchers be consulted as part of the classification development to provide insight into the use of the ANACC.
- Wide Bay HHS agreed that the *"comprehensive, mutually exclusive and consistent"* classification principle is important to ensure uniform application across different settings, however the HHS noted that procedural consultations may necessitate a different classification.
- Wide Bay HHS suggested that any population based classification incorporate the Socio-Economic Indexes for Areas (SEIFA) to consider the relative socio-economic advantage and disadvantage of areas within Australia.
- Wide Bay HHS raised a number of concerns regarding the specifications for bundled funding including: episode start and end criteria, evidence used to determine expected utilisation and the components / funding administered through bundled funding.

The Department notes the HHS's concerns regarding bundled funding and the limited detail provided in the ANACC paper. The Department recommends that IHPA expand the bundled pricing commentary to note that parameters associated with bundled funding will be explored as a separate piece of work. This would be achieved through consultation with relevant stakeholders, advisory committees and public consultation, where appropriate.

It is noted that the classification principle of *"utility beyond ABF"* describes how the ANACC will consider best practice, quality and safety and performance reporting; however, the Department recommends this classification principle be extended to elucidate patient-centric outcome based measures. As mentioned in the response to consultation question one, the integration of patient measured value into service delivery is an organisational priority in Queensland. Understanding if the care received benefited the patient's quality of life is an essential factor for sustainable, effective and consumer driven healthcare.

The Department recommends that IHPA progress the System Planning Branch proposal for the ICD-11 to be reviewed upon release to assess if it is appropriate to align the ANACC to this classification.

5. Proposed classification concepts and variables

5.1 Unit of count / activity

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?

All Queensland respondents advised that they supported the continued use of service events as the unit of count for the ANACC. A summary of feedback from Queensland stakeholders regarding the proposed definition and opportunities for improvement follows:

- Gold Coast HHS suggested incorporating the term "health intervention" into the definition; inclusion of this term would demonstrate a consistency of language and more accurately reflect activities integral to care delivery but may not have direct "therapeutic / clinical content".
- West Moreton HHS noted the current service event definition may exclude components such as diagnostic activities and not record the intervention with sufficient granularity.
- Healthcare Purchasing and Funding Branch suggested the third interaction criteria, under the revised service event definition, be changed from *"be provided by the patient in their own environment without the presence of a healthcare provider"* to *"be substituted via a self or carer administered intervention, in the patient's own environment"*.
- Wide Bay HHS and the Statistical Services Branch both commented that the criteria for self-care treatments should be clearly defined to ensure appropriate activities were recorded under this interaction type. It was suggested that specific interventions such as enteral nutrition and home haemodialysis should be listed to clearly demonstrate that other less invasive procedures, including self-taken diagnostic tests (e.g. blood sugar levels), are not within scope of the collection.
- Wide Bay HHS also noted the identified benefit *"better able to drive efficiency in the longer term and encourage clinicians to take a long term view of good practice care for their patients"* and commented that clinical staff have expressed an interest in exploring this benefit further and understanding the evidence base.

The Department agrees that at this point in time it is premature to introduce a time-based episode unit of count for non-admitted services and supports, for the purposes of data collection, the continued use of a service event for the basic unit of count.

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?

Queensland stakeholders expressed reservations about an episode being considered as a unit of count in the ANACC. All respondents noted the importance of understanding episodic care as opposed to individual treatments; however, feedback indicated the need for rigorous assessment to correctly define the parameters of an episode of care.

Gold Coast HHS commented that “episode” counting is considered appropriate as a long-term aim to incentivise flexibility and innovation, but must be recognised for its potential to reduce the sensitivity to fund on quality. Any bundling would need to ensure a minimum suite of services is delivered within the bundle. It is likely to be suitable only for very specific conditions with very consistent application of a standardised model of care. It is unlikely that there is enough evidence available to clearly understand the patient journey due to the variability of care pathways due to multiple providers, markets and geography.

Gold Coast HHS, Sunshine Coast HHS, Wide Bay HHS, Allied Health Professions’ Office of Queensland, System Planning Branch and the Healthcare Purchasing and Funding Branch all commented that episodic funding must be developed over time and based on linked patient data analyses and learnings from international services using this model and able to demonstrated positive organisational and patient outcomes. The criteria for an episodic unit must be linked to evidence based pathways where there is agreement on clinical care and frequency of treatment.

West Moreton HHS did not support an episode of care being used as the unit of count in the ANACC. The HHS commented that although it may recognise the potential for multidisciplinary treatments and better identification of resources used in those treatments, it does not necessarily provide sufficient granularity. Non-admitted treatment for chronic condition management may be over extended periods of time and therefore episodes may not be easily recognised.

Statistical Services Branch (SSB) noted that the use of the term “episode” for the ANACC is a different definition compared to admitted patient care. This may lead to confusion and inconsistency between admitted and non-admitted classifications. To demonstrate the potential for misunderstandings, SSB provided the following commentary: what would be the implications if a patient were receiving a non-admitted course of care (an “episode” under the proposed ANACC) which involves multiple “service events” and during the non-admitted episode the patient is admitted for an inpatient “episode of care?” In Queensland, datasets established by SSB use the term “continuous care” to describe ongoing treatment for a specific condition; as such, the different terminology used for admitted and non-admitted settings minimises misinterpretation and confusion.

eHealth Queensland (Digital Strategy Branch) raised concerns that for correct episode data to be available, patient data will need to be linked across data collection systems. This is not current practice and could be an issue given the system change dependency (and associated timeframes to implement). Data collection systems are at different stages of readiness and although they will need to be able to cope with this new requirement, there may be variation in complexity (impacting risk, timeframes etc.) to implement the required changes. Jurisdictions will need to assess the required changes, progress vendor changes and develop a roll out schedule. This would be a risk to the implementation of the ANACC.

While acknowledging the potential benefit of using episode as a unit of count for some conditions (e.g. chronic diseases and sub-acute care), the Department supports IHPA’s proposal for the first version of the ANACC to continue to use service event as the basic unit of count until suitable data and costings are available for evaluation. The Department recommends that information system capabilities also be considered to ensure jurisdictions have the capacity to collect accurate episode level data.

The Department reiterates SSB’s comments that using an existing term associated with admitted care, may lead to confusion. The Metadata Online Registry (METeOR) describes the data element ‘episode of admitted patient care’ as ‘the period of admitted patient care between a formal or statistical admission and a formal or statistical separation, characterised by only one care type’ (METeOR identifier 268956). The ANACC describes a non-admitted “episode of care” as *“all care and treatment within a defined period of time”*; patients can be admitted to hospital for multiple episodes for the same condition which conflicts with the non-admitted definition. The Department recommends that IHPA adopt the SSB data element “continuous care” to describe a non-admitted course of treatment thus distinguishing the non-admitted service from an admitted “episode of care”.

5.2 Diagnosis-type and intervention-type variables

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?

Queensland stakeholders recognised the importance of identifying chronic disease and multiply morbid patients but were generally not supportive of a separate classification path. A number of respondents raised concerns that data disaggregation will compromise future classification development.

West Moreton HHS and Wide Bay HHS collectively responded that the management of patients with multiple co-morbidities can be complex and resource intensive; as such, the system should be able to capture this care at a more granular level. The occurrence of chronic disease is increasing and HHSs have established defined care pathways linked to the Medical Benefits Schedule's healthcare management plans to better support this patient cohort.

Healthcare Purchasing and Funding Branch and System Planning Branch both commented that the problem / diagnosis-type and intervention-type groups presented at Appendix A of the consultation paper will not adequately cover complex patients will multiple co-morbidities. This issue highlights the broader issue of classification systems forcing a patient into one specific diagnosis; whereas, it is recognised most encounters arguably involve multiple morbidities. As far as practically possible, all morbidities should be captured in these patients, due to their higher healthcare needs.

Gold Coast HHS, Sunshine Coast HHS, Allied Health Professions' Office of Queensland and Statistical Services Branch commented that there are definite patient care advantages to classifying chronic disease patients; however, the ability report / collate / link relevant data with this type of classification will be difficult to manage with the current information. It is also worth noting that a separate classification path may result in data aggregation or disaggregation that could hinder future pathway development and / or care evaluation. Specific pathways for chronic disease patients may inadequately identify and / or recognise comorbidities requiring separate / additional services. The benefits of these would need to be clearly demonstrated to offset the additional workload.

Gold Coast HHS also commented that although some pathways for chronic disease management in primary care may be clear, they may be less so in the acute / primary transition space where there are few standardised protocols and pathways for medium to long-term patient management across sectors.

eHealth Queensland (Digital Strategy Branch) commented that as well as quarantining chronic disease patients, if a separate path is developed it will still need to consider the patient's complexity and health needs.. If a separate pathway was integrated into the funding model, a flat price per episode would over-compensate providers with less complex patients. As noted in previous responses, linked data collection systems must be available to enable care to be managed in acute settings and in collaboration with general practitioners.

The Department notes that patients with chronic diseases are not distinguishable in the problem / diagnosis-type and intervention-type groups presented at Appendix A; however, the comorbidities are listed as a complexity variable in section 5.3. The Department recommends that appropriate metrics be established in the ANACC to identify patients with chronic diseases and these be considered for future

versions, dependent on evidence provided through the collection of service event data and diagnosis–type and intervention-type variables.

The Department also recommends that any initiatives towards identifying and classifying chronic disease patients also consider co-morbid and complex patients. This patient cohort are at-risk and potentially significant consumers of clinical resources; therefore, liable to adverse outcomes.

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

Feedback from Queensland HHSs is that a minimum of two to five years would be required for consultation, development and implementation of a patient-based non-admitted care classification system.

To put this in context, Wide Bay HHS commented that the addition of the data element for a non-admitted multidisciplinary case conference where the patient is not present into the non-admitted dataset from 2018-2019, will require significant staff education and counting mechanisms to be effected prior to implementation, and this is not considered a significant model variation. The ANACC is a major conceptual and practical change to data collection processes and reporting criteria. This will affect staff across all disciplines. HHSs will be better positioned to estimate implementation timeframes as the classification is developed.

West Moreton HHS and eHealth Queensland (Digital Strategy Branch) commented that the implementation should include a timetable established well in advance to allow jurisdictions to plan and execute. It may take an extended period of time for jurisdictions to develop systems that will collect the necessary data and system roll outs. Releases can be slow or not synchronised (particularly across sectors and across jurisdictions) therefore the timetable should consider the risk associated with changes to the technological infrastructure. The implementation timeframe should also take into account the broader National Health Reform (NHR) agenda currently under discussion.

Gold Coast HHS noted the implementation timeframe would be dependent upon a number of factors:

- Information requirements of the classification, the necessary technology to deliver and the variable rate of digital upgrade across the healthcare system (especially for small facilities / providers.
- The cost of implementation.
- The collection mechanism: manual coding versus automation and associated validation cost; and
- Identification and development of appropriate coding resources, and training and resourcing of a workforce to effectively transition to the new classification system. Although the document suggests an additional workforce will not be required, this will be wholly dependent upon realisation of efficiency gains from technology that may be unachievable.

Statistical Services Branch reiterated the previous comments that investment must be made in establishing linked datasets and the timeframe to achieve this is currently unknown.

The Department notes feedback from Queensland stakeholders regarding challenges with estimating an implementation timeframe at this stage, given the testing and efficacy required around such a material classification change.

The Department recommends that IHPA develop an implementation timetable as a priority to provide clarity around expectations and enable jurisdictions to formulate strategies to support the implementation locally.

Consultation question:

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

Queensland stakeholders are supportive of the inclusion of a diagnosis-type variable in the ANACC; however, noted concerns with the workload required to collect the data and capacity of information systems to accurately record the information.

Gold Coast HHS, Sunshine Coast HHS, West Moreton HHS and Wide Bay HHS commented that if the intent is to move towards a patient-based classification system then it is important to have a diagnosis-type variable included for the patient to be correctly classified. Better classification may allow more appropriate resource determination and clinical decision-making. A diagnosis-type variable will also support mapping to existing code sets and development of patient journeys and pathways. However, this data element is not captured in the current Queensland Patient Administration Systems (PAS) and therefore may not be available in the medium term. Although the paper states it is a priority that the ANACC *"should not require a separate coding workforce and will need to occur using existing capabilities"* a number of HHSs indicated this commitment has not allayed their concerns regarding workload impact.

Wide Bay HHS noted the paper states *"feedback from clinicians and non-admitted care stakeholders is also that many patients may not have a known diagnosis when attending a non-admitted service therefore a variable of "diagnosis" may not be adequate for the non-admitted sector"*. The HHS suggested that the point in time and by whom the diagnosis is to be determined should be agreed as part of the classification development.

Gold Coast HHS commented that generally HHS managed services along specialty lines rather than diagnostic lines, therefore the ANACC may lose some utility as a performance management tool. The HHS proposed that diagnosis, intervention and outcomes be considered as data elements to generate the diagnosis-type variable.

The Allied Health Professions' Office of Queensland observed that the diagnosis-type groupings will require broad consultation across clinical areas and professional groups to ensure relevance and completeness.

System Planning Branch supported the three elements nominated under the diagnosis-type variable, including diagnosis, reason for encounter and presenting problem. The branch commented that this approach will better enable linkage to care in other settings and is useful for policy, funding and planning purposes.

The Department acknowledges that diagnosis-type information is a vital contributor to the new classification system and also supports the three elements recommended by IHPA to evaluate the diagnosis-type variable. The Department also notes comments from the Gold Coast HHS regarding additional data elements suitable for inclusion in the diagnosis-type variable; as such, the Department recommends that IHPA assess the feasibility of incorporating outcome measures as a variable.

The Department does however, concur with concerns raised by HHSs regarding workload impacts and additional resources potentially required to collect this information.

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”?

Queensland stakeholders expressed differing views regarding the suitability of “presenting problem” as a contributing element of the diagnosis-type variable. The concerns with this data element stem from data collection processes and whether accurate and consistent results will be available to produce the diagnosis-type. Following is a summary of concerns fed back through the jurisdictional consultation process:

- Gold Coast HHS proposed that the definition does not appear to be evidence based, nor used internationally and is therefore inconsistent with IHPA’s drive for an evidence-based framework;
- Gold Coast HHS, Wide Bay HHS, Healthcare Purchasing and Funding Branch and Statistical Services Branch consistently responded that the presenting problem may not adequately represent the reason for the visit. It reflects a variability that complicates analyses to determine need and demand. After clinical examination, a “sore foot” could be diagnosed as diabetes, gout, cellulitis, fracture or rheumatoid arthritis. It is also likely to encompass many uncommon “problems”’ that will be complex to link to scoped service requirements. How this data element will operate for allied health practitioners should also be considered. The primary reason for attendance may be “limited functionality” which cannot be captured or classified in the current list of present problems;
- Metro South HHS advised that there is currently sub-optimal data collection for “presenting problem” however it is anticipated that this will improve with the implementation of digital health systems. The HHS currently uses a “reason for referral” data element, which is free text and is highly variable between cases; and
- Sunshine Coast HHS supports “presenting problem” contributing to the diagnosis-type variable - acknowledging IHPA’s comments that further business rules need to be developed. The HHS noted concerns regarding how the diagnosis-type variable will be reported accurately, particularly given the classification is not predisposed to additional coding resources.

A number of HHSs and business units within the Department of Health also provided specific comments in relation to the definition and assessment criteria. Following is a summary of those remarks:

- Wide Bay HHS stated that “presenting problem” is a more suitable indicator to capture the reason the patient is receiving non-admitted services and is immediately and more easily grouped / defined.
- Allied Health Professions’ Office of Queensland noted that “presenting problem” aligns well with the allied health data element “clinical finding” which is included in the proposed National Allied Health Best Practice Data Sets. As discussed in the Consultation Paper, the presenting problem for an allied health service event may not be linked to the patient’s primary medical diagnosis.
- Metro South HHS suggested that Australian university health faculties are consulted in the development of the ANACC, as a significant portion of the workforce graduates through these institutions.
- System Planning Branch support the use of “presenting problem” in the allocation of the diagnosis-type variable; however, noted that linking the presenting problem to the original diagnosis would be useful for policy, funding and planning purposes.
- West Moreton HHS also support the use of “presenting problem” as the health issue the patient presents with is likely to be the most urgent matter requiring attention, care and therefore resources. The HHS commented that once the “presenting problem” is managed there may be other symptoms that are being addressed in the non-admitted setting prior to treating the underlying cause. Therefore use of the “presenting problem” is considered preferable to “diagnosis” or “reason for encounter”.

The Department supports the use of “presenting problem” as a contributing factor in the diagnosis-type variable however notes stakeholder concerns regarding the quality of the data element. The Department recommends that IHPA review current admitted and emergency datasets to understand the correlation between the principal diagnosis on admission and the principal diagnosis assigned in the Emergency Department (ED) for patients admitted through the ED. Although the ED principal diagnosis is not the presenting problem (as it is determined after clinical examination), this analysis could provide an indication of the consistency between diagnoses recorded in different settings.

The Department also supports the Metro South HHS suggestion that input is sought from Australian university health faculties and recommends that IHPA engage these institutions as part of the classification development.

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?

Queensland stakeholders provided detailed feedback on the proposed list of initial presenting problem / diagnosis-type and intervention-type groups presented in Appendix A. Queensland stakeholders appreciate this is a preliminary list of variables that will be refined as part of the classification development. Following is the overarching feedback regarding the variables from the jurisdictional consultation process:

- Gold Coast HHS and Healthcare Purchasing and Funding Branch both commented that the list is closely aligned to the acute care phase and will be problematic for chronic, complex and co-morbid patients.
- Healthcare Purchasing and Funding Branch also commented that the list does not adequately consider preventative / screening services, pharmacy interventions, patients requiring care for long term issues, general functional decline and palliative care (for palliative care patients the diagnosis is clear but the presenting problem is not necessarily the diagnosis but the loss of functionality / quality of life). The branch noted that, for the aforementioned patients, the “reason for encounter” may be a valuable variable to use in the classification.
- Gold Coast HHS also remarked that the list is not consistent with the Medicare Benefits Scheme, although, such direct alignment may not always be resource comparable between the acute and primary care sector. The HHS also noted the list does not adequately reflect the biopsychosocial model of population presentations nor evidence-based care delivery.
- Sunshine Coast HHS stated the HHS supports the proposed list and information gained from the presenting problem / diagnosis will assist with research; however, it will require a significant change to the business processes and non-admitted systems to enable collection of this information (the HHS noted that IHPA have acknowledged this challenge in the paper).
- Gold Coast HHS, Allied Health Professions’ Office of Queensland and System Planning Branch all commented the list will require broad consultation across the range of service areas and professional groups, including disease-specific experts, researchers and clinicians. It was suggested that the Australian Classification of Health Interventions (ACHI) codes should also be considered for identifying non-admitted interventions and procedures.
- Wide Bay HHS noted that complications of care are an important quality and safety measure not currently reported in the non-admitted environment however, the HHS suggested that the interaction with Hospital Acquired Complications (HAC) be investigated further as part of the classification development.

- eHealth Queensland (Digital Strategy Branch) commented - for a number of patient level grouping variables - the proposed intervention type groupings cannot sufficiently address all of the proposed presenting problems / diagnosis-type groupings. For example, "*MDC19 Mental Diseases and Disorders"* only have one proposed intervention-type grouping against nine proposed "presenting problem" groupings.

Following are the detailed responses related to specific patient-level groupings from Queensland stakeholders:

MDC 02 Diseases and Disorders of the Eye

- Statistical Services Branch (SSB) raised concerns regarding the inclusion of "ophthalmic procedures for trauma" due to the potential for infection.
- SSB also commented there is a risk of clinicians interpreting the intervention-type groupings for some procedures differently, for example, "retinal detachment procedures (simple)".

MDC 03 Diseases and Disorders of the Ear, Nose, Mouth and Throat

- SSB raised concerns about the intervention-type groupings "myringotomy with tube insertion" and "upper airway endoscopy" being performed in a non-admitted capacity due to the complexities associated with paediatric patients and the use of general anaesthesia with invasive procedures such as an excision of lesion or insertion of stent.
- Office of the Chief Dental Officer noted there are two dental items in the intervention-type groupings however there are no dental "presenting problems". It was suggested that either "dental" be added as a "presenting problem" and the list of dental interventions retained, or in the absence of a dental "presenting problems" the dental interventions be removed as these do not correlate to any other presenting problems / diagnostic-type groupings.

MDC 04 Disease and Disorders of the Respiratory System

- SSB queried whether "invasive ventilatory support – tracheostomy" refers to long-term care or the insertion of a tracheostomy. Further clarification regarding the scope and criteria of the grouping will be required.
- SSB supported the inclusion of "polysomnography (sleep study)" as an intervention-type grouping.

MDC 05 Diseases and Disorders of the Circulatory System

- SSB reiterated previously noted concerns regarding some interventions being performed in a non-admitted setting. These include "implantation of replacement of pacemaker", "percutaneous transluminal coronary angioplasty (PTCA)" and "percutaneous transluminal rotational atherectomy". All of these procedures need to be undertaken in a facility that has at a minimum cardiac catheter lab capacity and access to cardiac surgeon in case of an adverse event. Anecdotal evidence of current practice for interventional cardiology is for the patient to undergo an angiogram as a non-admitted patient and if a PTCA is required then the patient is admitted for the procedure.

MDC 06 Diseases and Disorders of the Digestive System

- SSB queried whether "hernia procedures" refers to manual, laparoscopic or open procedures; as noted previously, further clarification regarding the scope and criteria of the grouping will be required.
- SSB also commented that endoscopies performed in the non-admitted setting - when an intra / post procedural complication occurs -the patient's non-admitted service event is completed and the patient is then admitted with a complication "present on admission" such as an intestinal perforation. This will affect safety and quality reporting indicators such as unplanned readmissions.

MDC 08 Diseases and Disorders of the Musculoskeletal System and Connective Tissue

- SSB suggested that spinal percutaneous neurotomy for facet joint via radiofrequency ablation is included as the number of these procedures being performed is increasing.

MDC 10 Endocrine, Nutritional and Metabolic Diseases and Disorder

- SSB reiterated previously noted concerns regarding some interventions being performed in a non-admitted setting. The branch noted that paediatric patients are generally admitted overnight for "insertion of insulin pump".
- Wide Bay HHS suggested that Home Enteral Nutrition and Parenteral Nutrition be included in the proposed intervention-type groupings.

MDC 12 Diseases and Disorders of the Male Reproductive System

- SSB noted that rural and remoteness is a factor for some interventions such as circumcisions.

MDC 13 Diseases and Disorders of the Female Reproductive System

- SSB does not support "destructive procedures on cervix", "dilation and curettage (D&C)" and "gynaecological endoscopy" being provided in a non-admitted patient setting.

MDC 14 Pregnancy, Childbirth and the Puerperium

- As noted for "MDC 13 Diseases and Disorders of the Female Reproductive System", SSB does not support D&C being provided in a non-admitted setting.

MDC 17 Neoplastic Disorders (Haematological and Solid Neoplasms)

- SSB supported "chemotherapy" being delivered in a non-admitted setting however noted that further detail will need to be provided regarding the treatment of subcutaneous hormone therapy related to chemotherapy and, if the insertion of venous access device is included, then removal and management of the device should also be included.

The Department notes that this is an initial list of variables and the scope / criteria associated with the groupings will be determined and clarified as the ANACC is developed. The Department does however suggest that IHPA provide clarification regarding the treatment of patients requiring general anaesthesia / sedation, adult / paediatric services and where allied health interventions fit into the classification.

The Department recognises the issue identified by eHealth Queensland (Digital Strategy Branch) where, for a number of patient level grouping variables, the proposed intervention-type groupings do not sufficiently address all of the proposed presenting problems / diagnosis-type groupings. The Department recommends further consultation occur with the IHPA Clinical Advisory Committee to expand the list of intervention-type groupings as a priority.

As mentioned in the response to consultation questions one and four incorporating patient measured value into service delivery is an organisational priority in Queensland. The Department recommends IHPA consider Wide Bay HHS's proposal to investigate how HACs can be integrated into the ANACC.

The Department recommends that IHPA update the intervention-type groupings for "MDC 03 Diseases and Disorders of the Ear, Nose, Mouth and Throat" as per the advice provided by the Office of the Chief Dental Officer.

5.3 Complexity variables

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?

Queensland stakeholders all responded positively to the suggested complexity variables. Based on feedback received from Gold Coast HHS, West Moreton HHS, Wide Bay HHS, eHealth Queensland (Digital Strategy Branch), Healthcare Purchasing and Funding Branch, Statistical Services Branch (SSB) and System Planning Branch, the Department notes the following additional complexity variables that should be considered for the ANACC:

- Elective / emergency status for inpatient referrals
- New / review appointment type
- Information that can be extracted from the referral
- Whether services are provided via a face to face consultation, telehealth services or via telephone
- Statistical Area Level 2 (SA2) or postcode of residence to enable attribution of remoteness and / or socio-economic status
- Location of care delivery to examine the cost differential between remote and metropolitan facilities
- Aboriginal and Torres Strait Islander status
- Cultural and linguistic diversity.
- Disability status: Queensland stakeholders suggest using the Core Activity Need for Assistance (ASSNP) which is derived from questions 20 to 23 on the Census Household Form (ABS Census 2018)[2].
- Consideration will need to be given to whether complexity drives variation in resources required per service or whether it drives the number of services required in an episode of care.
- Use of technology to allow for future modalities of care.
- Functionality score for patients rehabilitation or Geriatric Evaluation and Management and also situations where the “presenting problem” is not easily identifiable.

The Department recommends that complexity variables be derived from known demographic data elements linked to healthcare use and outcomes. The Department also strongly recommends ‘ ‘age’ be included in the final list of complexity variables. It is acknowledged that there can be increased cost with the treatment and management of paediatric patients however, it is also a jurisdictional strategic priority to improve clinical outcomes for frail and / or elderly patients. It is important that this patient cohort is identifiable in the ANACC as inappropriate admissions and unnecessarily long periods in hospital can contribute to a frail older person declining in function to a point where they are unable to return home. Better management of this patient group in the non-admitted setting will decrease hospital admissions and the associated risks of harm and other potential complexities such as acute confusion, falls and pressure injuries.

A number of respondents raised concerns with the ability to identify, classify, capture, link and report relevant data for the comorbidity variable and the subsequent workload to support data collection. SSB noted that it is a risk to assume these issues will be resolved with the evolution of digital healthcare. The capture of comorbid data in admitted episodes of care is guided by Australian Coding Standards and may

[2] Australian Bureau of Statistics (ABS) 2018. *Core Activity Need for Assistance*. Retrieved 23 February 2018 from: http://www.abs.gov.au/websitedbs/censushome.nsf/4a256353001af3ed4b2562bb00121564/ee5261c88952cf90ca257aa10005f567!OpenDocument

not capture the same level of detail required for the ANACC (automatic use of previously documented conditions is also a risk as comorbid conditions can change over time). The Department recommends that prior to the implementation of the ANACC, IHPA commission a thorough pilot study to accurately assess the impact to resources and costs associated with the collection.