Queensland Government

Health Service Chief Executives' Forum

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Mr James Downie
Chief Executive Officer
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PO Box 483
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Via email: submissions.ihpa@ihpa.gov.au

Dear Mr Downie

Re: Independent Hospital Pricing Authority public consultation paper on the development of the Australian Non-Admitted Care Classification

The Health Service Chief Executives Forum writes as submission to the above consultation paper on behalf of the Queensland Hospital and Health Services.

The following comments are provided in addition to the response to the 12 questions asked in the consultation paper (attachment 1) with the aim to supporting a robust activity based funding classification system for non-admitted care.

- The cost of providing ambulatory clinics or service events is primarily driven by the labour cost of the attending clinicians, accordingly services provided by senior doctors or visiting medical officers are much more expensive than nurse or allied health professional led services—Currently Tier 2 clinic codes provide a proxy for labour costs—banding the labour cost may be necessary
- Service duration times are poorly captured in current information systems, the duration for which these resources are used for each patient varies between the needs of patients and New and Review status—New and Review flags currently provide a proxy for duration
- No diagnoses are currently captured with Corporate Clinical Codes or Tier 2 specialty as a poor indicator of underlying disease, particularly prior to any diagnostics—Diagnostic test costs are currently matched using date/time stamps only, with no definitive link back to originating service event
- Diagnostics contribute additional costs, particularly where the test is expensive (e.g. MRI), with the diagnostics specific to the characteristics of patients (i.e. diagnosis) rather than care setting or the type of attending clinicians, and with most diagnostics being provided at a different time and/or date than the non-admitted service event itself—correct linkage between diagnostic costs and the original service event is critical to robust ABF funding—a unique referral or appointment ID code would provide a link between diagnostics and originating service events

- Procedural services may use specialised equipment or consumables and these may be driven by the setting (e.g. minor procedure room) rather than patient diagnosis
- Diagnoses coding to support grouping of clinically meaningful patient cohorts together—a compulsory mechanism to link any diagnostics back (or forward) to the originating non-admitted service event is required

In addition the discussion paper assumes that introduction of ieMR will improve and broaden availability of non-admitted patient treatment information. It is worthy to note the current Queensland experience demonstrates very little evidence of this.

Should you require further information on the content of this submission please do not hesitate to contact Heather Edwards—Executive Officer HSCE Forum Office on 07 3708 5425 or HSCE-Forum-Office@health.qld.gov.au .

Yours sincerely

Adrian Pennington
Chair—Health Service Chief Executives' Forum
29 March 2018

Attachment 1

Q 1	Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?
Answer	Yes, the new classification for non-admitted care should support the delivery of integrated care between health care settings: • contemporary models of care and across various settings, with there being potential for much more homogeneous care • incentives towards better management of patients within the 'system' of health care and allow for patients to move efficiently between health care settings as needed • enabling integrated models and bundled models of care • recognition of changes in models of care and varied settings for treatment such as allowing traditionally community based care to be acceptable within a hospital-based environment and vice versa • banding the labour costs used to provide the services i.e. the cost of providing ambulatory clinics or service events is primarily driven by the labour cost of the attending clinicians. Services provided by senior doctors or VMOs are much more expensive than nurse led or allied health services.
Q 2	Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?
Answer	Yes, classification for non-admitted care services should be flexible and be able to adapt to emerging models of care, including: • case management of complex and chronic disease cohort (nurse navigator model) and other hospital avoidance programs • that it must be structured in such a way to take into account the best evidenced and best care practice for a given patient group and incentivise or penalise providers to converge towards the best evidence through price signals • technology, telehealth and tele-monitoring are enablers to improved care and should not be looked at in isolation.
Q 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?
Answer	The future ANACC system needs to be expanded and refined as needed i.e. in the same way other ABF classifications are developed. It also needs to: • provide a funding model flexible enough to fund different providers and shared care • expect a shift away from admitted/non-admitted funding models to bundled services for chronic disease and complex care to allow the system to consider patient services in total, not components of care • link evidence based pathway to presenting condition not dependent on where or by whom the care is provided • be supported by agreement on evidence based pathways which is integral to ensuring effective and value based healthcare • note mental health care is considered out of scope and will be classified through the Australian Mental Health Care Classification—given many Queensland HHSs count acute mental health activity as part of their monthly outpatient collection, we are keen to understand any associated funding adjustment, i.e. back-casting to exclude this activity • consider what activity measures are used—adoption of a new classification system

	could impact historical activity levels and Commonwealth funding, i.e. NWAU delivery. i.e. should IHPA move to bundled episode to define service delivery, how will this impact Queensland HHSs Service Agreement s and (historical) activity funding • consider the increased resource requirement associated with the proposed non-admitted data capture and coding, noting expertise will be required for some data elements, i.e. diagnosis, should be clinical responsibility not administrative staff • have more information and reference to referrals and how they relate
Q 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?
Answer	Agree in principle: • The principles are many and pertinent (albeit aspirational) but there are a number which maybe not be practical or achievable without resources to modify and enhance source data systems. E.g. applying "The classification relies on data elements that are collected consistently and uniformly" gives the status quo: Tier 2 clinic codes. The lowest common denominator from source systems is low indeed, and ieMR may not improve this appreciably. • the classification should be applied consistently across different settings for consultations noting procedural consults may need different classification • clarification is required on whether the proposed outputs can enable an improved patient experience. Many of these principles could act as proxies for this (e.g. one could expect that a more integrated system should in theory allow for patients to better move between care systems and between care providers). However, it is always important to keep the patient, the quality of care provided and their experience at the forefront of any change. • 'Bundled pricing would provide one bundled price for all of a patient's admitted and non- admitted care for a particular condition': clarification on the components and funding is required as resource homogeneity is very difficult with bundled services. There will be large variations in cost due to diagnostic tests ordered and drugs issued. To achieve reasonably homogenous costs, diagnostics and drugs would need to be unbundled. This could then lead to uncapped ordering. If IHPA moves to a bundled payment for non-admitted services, assume monthly bundles similar to home haemodialysis. What are the parameters around bundled and capitation model funding, for example: – When episodes start and cease, i.e. Irish model is 28 days – Expected interventions in the monthly period; assume based on classification based on EBP/expected healthcare utilisation – Need to understand the evidence how capitation models offer improved efficiency and health outcomes for patients – More detail required around 'data elements that reflect the characteristics of patient • Introduction (or migration) of a new classification system may incur additional human resourcing; this is regardless of the classification principles and their intent. E.g. if IHPA introduce a classification system whereby each service event is 'coded' it is envisaged that additional coders or trained staff would have to be employed to read charts and check the 'coding' entered into the system.

	• Clarification is sought around current 'out of scope for the purposes of ABF' services for inclusion in the new classification model • Population based funding should recognise SEIFA indicators to inform HHS funding adjustments
Q 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?
Answer	There is no opposition to the proposed revised service event definition as service event has proved to be reliable, and is supported by source information systems. Although: • The existing definition needs to be explicit that care co-ordination without treatment does not constitute a clinical service event • IHPAs current interpretation of this, where discrete events from the same specialty on the same day are excluded (e.g. antenatal and midwifery clinics) are contradictory and do not reflect either current clinical practice or the cost of service provision. • In the short to medium term, it will be difficult to move away from service events as the counting method. The option of service events bundling into an episode of care is perhaps the right direction in the short to medium term with a view for the longer term in potentially going to episode of care for funding purposes (albeit it is unlikely this will stop the counting of service events as this is an important number for resource planning purposes). • There is a lack of detail for the hybrid of service option and events aggregated into episodes of care—this will be important before the system moves down a new ANACC system • Where the "interaction may be provided by the patient in their own environment without the presence of a healthcare provider", what is the trigger to count this event? Is it related to 'treatment provision', i.e. enteral nutrition, home haemodialysis or transfer of self-taken diagnostic test results, i.e. BSL? • "Identified benefits of an episode based unit of count include: better able to drive efficiency in the longer term and encourage clinicians to take a long term view of good practice care for their patient" (page 24): keen to have this expanded and the supporting evidence supplied
Q 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?
Answer	As mentioned above in 5, the episode of care as a counting unit should be considered. An episode be considered as a unit of count: • is likely to be the best unit of measurement for patients that could be better managed predominantly outside the hospital setting (e.g. chronic disease patients are the obvious here but there could be others as technology enables improvements to care delivery for patients to better self-manage or be managed remotely). • If the reference is to 'bundling occasions of service/presentations' into 'episodes', this should be linked to Evidence based pathway where there is agreement on clinical care and frequency Difficulty with an episode be considered as a unit could be encountered where care and treatment may be shared across a number of providers such as: • antenatal classes may be provided by a public facility, but childbirth may occur at a private facility. Without agreement and endorsement from respected groups of clinicians (i.e. Colleges) as to what constitutes an agreed treatment plan and care

	pathway, there will continue to be variations in services and cost. Adopting an episodic payment system encourages reduction of services to a minimal provision to maximise profitability. This is not in the patient's best interest. • Non-admitted patients that may have higher rates of interface with the acute setting (e.g. surgical pre and post op patients) are less likely to be better counted in this way as the nature of their care is relatively more transactional. In the first instance specific conditions used need to have underlying evidence based pathways where there is agreement on clinical care and frequency with minimal variation.
Q 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?
Answer	The nature of care between chronic disease patients and other non-admitted care that has an interface with the acute system (e.g. pre and post op clinic visits) are very different. To that end, it does make sense to consider a separate ANACC system for chronic disease patients as chronic diseases has defined care pathways and are linked to Medical Benefits Schedule and healthcare management plans and considered suitable for episodic bundling. Having a separate system for chronic disease patients could allow for different funding models (like capitation) where it could provide more incentive to better manage these patients in the community and away from the acute system. Management of chronic disease does not fit comfortably in any ABF model, as care spans a larger number of providers, primary, secondary and community care, and the public and private sectors. It makes more sense to manage chronic disease holistically (through capitated care plans, US style managed care organisations, or NDIS style treatment credits) than to fund ABF components separately.
Q 8	What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?
Answer	For the majority of HHSs the main impediment is availability of source data at the level of granularity required. Existing systems (including ieMR) would need expensive enhancements, with data entry training to follow. This would be best managed corporately to ensure consistency for benchmarking and mandatory data submissions. Given the testing and efficacy required around such a material funding model change, and the current change programs currently being rolled out in Queensland, a minimum of 3 – 5 years will be required for consultation, development and implementation of non-admitted model change. As an example, the pending non-admitted multidisciplinary case conference where the patient is not present change for 2018-19 will require significant staff education and counting mechanisms to be effected prior to implementation and this is not considered a significant model variation. New systems (like the iEMR) and data capture methods may be required to move towards the proposed ANACC (or a similar variant). It has taken many years for outpatients to get to this point of capturing data (and this is still improving) and so lead times of at least three financial years may be necessary once an agreed model has been decided. There also may need to be a phased implementation approach to a new ANACC system, particularly if a separate system is agreed for the classification, counting and funding of chronic disease patients and those that are linked to acute services.

Q 9	What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?
Answer	Diagnosis-type information is a vital contributor to a new classification system although it is necessary to consider single, principle and multiple diagnosis options, for the following reasons: • A single diagnosis per referral is problematic, as the needs and condition of the patient will change over the course of non-admitted treatment. That's the purpose of treatment after all. So diagnosis would need to be specific to each service event, and diagnostic testing would need to be linked back to each service event for robust costing and funding. • In addition material information system modification will be required to collect diagnosis-type classifications for non-admitted patients and how will this information be collected and submitted?; data collection workload • Who and at what point in episode will the diagnosis be agreed and collected given diagnosis is not always clear on initial specialist consultation • Within Queensland, major emergency departments use the EDIS information system—this system uses presenting problem and is free text linked to a complaint code from picklist; what is the source of these reference tables and primary diagnosis are from ICD-10 • The paper has outlined limitations associated with data capture and clinical concerns around patients who do not have a primary diagnosis when attending a non-admitted service. However, another variable to consider is the balance between depth of diagnosis-type variable and the flexibility for alternative funding models in the future. • A patient classification system using diagnosis for non-admitted service could allow for bundled or capitated funding models for chronic disease patients. However, it is also unlikely to be a helpful classification method for patients accessing a hospital-based outpatients area for a follow up appointment for a post-operative procedure (as their care is likely to be much more transactional with the system). A one size fits all approach here is unlikely to be the optimal way forward because of these two distinct patient cohorts.
Q 10	Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'?
Answer	No. All three options presented assume that "episode" is the level of classification. The arguments against 'diagnosis code' are moot if diagnosis is recorded for each service event and change and develop over time. They would also more accurately match the diagnostic testing provided. Similar to the above point (answer 9), presenting problem is likely to be an effective classification system for a non-admitted service, where a patient is likely to require further hospitalisation/acute planned care or is a first time presenting chronic disease patient. This form of classification would for these patients be compatible with an ABF model. However, it is likely to be an ineffective classification method to inform innovative funding models (in the Australian context) for chronic disease patients (as indicated above). It is agreed 'presenting problem' better captures the reason the patient is received non-admitted services and is immediately and more easily grouped/defined. However clinical indications can be similar but diagnosis and treatment vary significantly, i.e. 'sore neck' as early indicator of pending cardiac event OR musculoskeletal soft tissue over- use injury.

Q 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?
Answer	The Presenting Problems shown in Appendix A are reasonable, but do not indicate severity and is therefore not robust. Initial view is that this list seems to strongly resemble the AR-DRG classification method. This may be useful for non-admitted patients that have previous or are about to have an acute admission, however, does not seem conducive for creating incentives to better manage, multi-morbidity, chronic disease patients outside the hospital setting. As previously mentioned, the bigger point is whether one ANACC provides the best incentives to better manage these patients. The list is not exhaustive and would benefit from extensive review/research, but is worthy of further investigation. If adopted: • it is unlikely the Presenting Problem code would change over time, even though the patient's needs should reduce, immediately this introduces cost variation driven by the classification system, not the patient's health status. For example MDC 10 Endocrine, Nutritional and Metabolic Diseases and Disorder, we would consider Home Enteral Nutrition and Parenteral Nutrition should be included as Proposed intervention-type groupings; • Care complication is an important quality and safety measure not reported in the non- admitted environment; the interaction with Hospital Acquired Complication (HAC) measures needs further investigation Consideration around separate ANACC systems may be better (i.e. at least one system that better incentives management of chronic disease patients away from the hospital setting).
Q 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?
Answer	Noting difficulties as per Q9 answer above around capture in information systems with some of the points not being complexities but proxies for cost. Other concerns/variables include: • Age may advise a course of treatment, but does not drive it. If a significant correlation with cost is confirmed for some diagnoses, then include a modifier • Comorbidities complicate treatment, particularly in selection of drugs. However the major comorbidities are chronic diseases, and these are best managed separately as discussed earlier • Multi-disciplinary is simply a proxy for increased labour cost • New/Repeat visit is a valid explanatory variable for the number and type of diagnostic tests ordered, but capture of duration of service event would result in more robust attribution of labour costs • Providers is a proxy for labour cost • Is location another variable for consideration, i.e. regional and remote services, tertiary services; • How will co-morbidities be identified, classified, captured and reported? • Indigenous status • Clinical risk See point above. Example presented seems ideal for care that has strong linkages to other hospital-based services, but unlikely to drive the types of incentives needed to better manage chronic disease patients.