IPHA Public consultation open – Australian Non-admitted Care Classification

Activity Based Management Committee Members Feedback

Glen Kennedy, A/ Executive Director, Cancer Care Services

Issues identified:

- Creation of the episodes of care
- All consults map to an episode of care, there is significant complexity associated with this
- There is significant number of diagnostic groups which overlap, transit from one diagnosis to another as the disease progressed, how is this accounted for
- Coding implications around this clinics – given these are outpatient clinics this should not impact

Private v Public

Private

- Stepping away from fee for service models with rationale that FFS drives over-servicing

Public

- Administrative complexity
- Coding
- Outcome of the change is unknown
- Not viable

Would need to define diagnosis further, eg how long does a group go for? Does it include ongoing maintenance, treatment and follow up

Don't support episode of care and diagnostic groups

Michael Elliott, Business Manager, CISS

Responses to Consultation Questions

1. Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how? Yes, need an integrated IT solution and classification system to support this.
2. Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how? Yes. Ability to specify how care is delivered as not all care is traditionally delivered face to face e.g. home monitoring models.
3. As the type of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes? Consultation, understanding varying and changing models of care.
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? Agree
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? Yes service event is relevant, duration needs to be considered.
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? Agree, service events link to an episode. Episode needs to be defined for community.
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? Unsure

8. What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system? 2 years
9. What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system? Unsure
10. Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'? Yes
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? This list does not reflect our patient types
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? Agree, unsure of what else need to be considered