Royal Rehab
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Mr Darren Viskovich
Secretariat and Licensing Officer
Office of CEO, Independent Hospital Pricing Authority

Via email: darren.viskovich@ihpa.gov.au

Dear Darren

Please find attached a copy of Royal Rehab's submission to the current IPHA Australian Non-Admitted Care Classification Consultation. Thank you for permitted a late submission, which has also been lodged through the nominated link.

There are a number of quite unique features of the non-admitted specialist services which Royal Rehab provides, particularly to patients with traumatic and acquired brain injury, traumatic spinal cord injury or multi-trauma injuries, across metropolitan, regional and in some instances remote settings which may not align entirely with the proposed ANACC, although we acknowledge that it is a most significantly improved system to the current Tier 2 Classification.

We would be most willing to provide additional case examples or input as the ANACC model evolves, or to participate in any forums or working parties to further develop these principles, should the opportunity arise.

Yours sincerely

Stephen Lowndes
Chief Executive Officer

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Submission to the Independent Hospital Pricing Authority April 2018

Development of the Australian Non-Admitted Care Classification (ANACC)

Royal Rehab welcomes the opportunity to respond to the current Independent Hospital Pricing Authority's (IHPA) development of the new Australian Non-Admitted Care Classification (ANACC).

Royal Rehab is a public health funded provider (through Northern Sydney LHD) of specialist statewide sub-acute and non-admitted specialty services predominantly supporting clients with complex Acquired Brain Injury (ABI) and Spinal Cord Injury (SCI). The services are delivered by highly specialised multidisciplinary allied health, nursing and medical teams. A significant component of our activity is non-admitted care in the SCI and ACI populations as well as the general rehab population with Home Based Rehab Services and general outpatient clinics.

General Comments:

We are pleased to see the work being done on a new classification system with recognition of the current failings and limitations of the Tier 2 clinic-based system. Another significant improvement with this newly proposed classification is the consideration of the setting of non-admitted service delivery, with previous classification systems and funding clearly designed to better count and fund centre-based services (classic "outpatient" appointment). Given our statewide services are designed to support clients' integration into their home and community environment, the majority of our services are not delivered in an hospital outpatient setting, which significantly contributes to duration of service delivery and therefore cost.

We agree that developing a system that is patient-centric has value and aligning and integrating with other classifications will improve data collection long term that improves opportunities to track and describe the client journey to enhance service planning and monitoring. However, we also recognise that this is ambitious and fraught with challenges, especially in relation to the lack of data system integration across healthcare providers. Understanding the client journey is particularly relevant for the specialist areas of Spinal and Brain Injury as these are lifelong in nature and result in ongoing periodic health issues, especially in relation to spinal cord injury.

Royal Rehab is interested in how this new classification system will capture the lengthy non-admitted episodes of care our clients have post discharge from hospital. The nature of catastrophic injury means that many areas of a person's life can be impacted by a sudden injury and the time needed for adjustment and support in transitioning to the community can take many months and frequently more than one year.

The new classification system needs to understand these complex types of "episodes" and should allow for flexibility in adding additional complex health problems that emerge and significantly drive cost through greater intensity of clinician involvement at various points of their episode. A key mandate for our statewide services is to support clients with adjustment to injury and focus heavily on health education and development of self-management skills to maintain and enhance client wellness to reduce the risk of future acute admissions and ensure they can lead productive lives in the community. The ANACC classification would also need to make allowances for these purposes as per the WHO definition of a health intervention outlined in the consultation paper "*A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve,* ***maintain, promote*** *or modify health, functioning or health conditions*"

Below are two brief case examples that demonstrated the complexity of the clients that a frequently seen within our services. Whilst recognising that this consultation paper is at conceptual level it is difficult to understand the finer details it will use to adequately count and represent current community rehab service delivery.

1. **Spinal Cord Injury (SCI) – presenting diagnosis, problems and goals of interventions**

Diagnosis: 67 year old male with non-traumatic SCI caused by spinal infarct following a cardiac arrest. Resulting injury T12 AIS B.

Presenting Problems:

- On admission: neurogenic bladder (expensive medication management); daily bowel accidents; impaired sexual function; unable to drive and access community
- Developed during admission: grade 2 pressure injury; fall out of wheelchair with resulting knee injury.

Comorbidities/Complexities: Non-Hodgkin's Lymphoma; limited community access; unable to drive; financial stress

Goals of Interventions: review bladder management; reduce bowel accidents and have a manageable bowel routine; heal pressure injury and review seating for pressure care; support with return to driving including advocacy; advocacy to local council to have kerb side cuts at local intersection to allow access to local community; sexuality counselling and support; alleviate financial stress through review of benefits and entitlements; bathroom modifications; manage knee injury through assessment by acute services and follow up support to prevent future falls.

MDT Clinicians: Spinal Registrar, Clinical Nurse Specialist, Physiotherapist, Occupational Therapist, Social Worker.

Service Delivery Challenges: service needs to be provided in client's home area to address local issues to home environment and community access. Client lives on the outskirts of metropolitan area resulting in 2 hour return journey for clinicians. Clinicians spending many hours in case planning activities for advocacy purposes to address community access requirements.

2. Traumatic Brain Injury (TBI) – presenting diagnosis, problems and goals of interventions

Diagnosis: 52 year old male, TBI (post fall)

Presenting Problems:

- On admission: Post traumatic seizures; behavioural issues; speech and language deficits
- Developed during admission: injuries from falls while intoxicated;

Comorbidities/Complexities: Alcohol dependence; no informal supports; type 2 diabetes, hearing impairment, cataracts; lower back pain; rotator cuff tear; multiple psychosocial issues; financial limitations;

Goals of Interventions: support with service navigation; speech therapy program; return to work; return to driving; formal carer training; behaviour management strategies.

MDT Clinicians: Rehab Physician, Case Manager, Speech Pathologist, Physiotherapist, Occupational Therapist, Social Worker

Service Delivery Challenges: Due to aggressive behaviour and client has no informal support the service needs to send two clinicians for each visit. Visits occur in the community with clinicians traveling to clients home, place of work as needed resulting in minimum 1 hour return journey. Client requires ongoing goal based support for a period of almost two years.

Response 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?

Royal Rehab considers this an important consideration. The consultation paper mentions innovative models for chronic and complex care such as outreach, whereby inpatient specialist teams support the community based services with specialised knowledge. In the case of SCI many clients receive their initial

hospital rehab in a non-spinal specific rehab unit which creates opportunities for in-reach models whereby the specialist inpatient or community service can support non-specialist inpatient facilities to manage clients with catastrophic injuries to support comprehensive and specialised discharge planning and client education.

The data collection needs to be compatible (if not the same) as for the inpatient setting to avoid data inconsistencies

There is risk that the establishment of domains of service that are not covered by the ANACC system (eg mental health) will undermine the system (what about depression secondary to a medical illness; psychosis as a complication of illness/treatment etc)

Unless economical recording systems are able to be established in the non-admitted setting, then this will not be viable. There may be electronic and data clustering approaches to simplify collection for specialty settings or defined groups (similar to those developed for the WHO-ICF)

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

Any new classification system should be flexible enough to allow services to trial these new technologies and models of care without the need to constantly revise internal data systems to capture the granular data needed for the ANACC. However, the greatest challenge with technology, to either deliver health care or capture and report data, is the multiple systems being used by various health services and states making unified data collection and transmission difficult.

The challenge relates to the nature of change in health models and technologies. A suitable definition for "newer models of care and technology" would assist analysis of impact and adoption. Changes are likely to range in their novel aspects from incremental change to a shift in Concept or Application.

Perhaps the classification system data collection should have a self-reflective data element encouraging reporting of items thought to fit poorly with-in the allocated data class. Modification of the data classification could follow scrutiny of these items. Other approaches could include assessment of outliers for features of classness and evidence of the impact of these factors.

Data collection should be designed with items that drive behaviour in desirable directions from the point of view of quality of service, efficacy and efficiency

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?**

Capturing all details of service delivery at the most granular level, even as it changes, would go some way to managing the changing models as then, only the clustering or grouping of this granular data would need to change reducing the impact on initial data capture that is generally completed by clinicians. Making changes to software systems to allow for revised data capture requirements is a significant cost for organisations to continually absorb as service models and pricing frameworks change over time and any classification system should minimise the chance of inflicting these costs on health services.

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?**

Royal Rehab are supportive of the classification principles that prevent services from gaming to improve their funding situation and agree they should be applied consistently reflecting characteristics of the patients.

However it will be challenging to create classifications that achieve "resource use homogeneity" by "explaining a substantial level of the cost variations" when accommodating a long episode duration, involving complex, client goal directed care. The individual patient motivations and rehab goals become drivers of costs that may not be seen in another patient with the same diagnosis and presenting problems, with flexibility required to accommodate this variable.

With the extensive list of principles, it seems inevitable that decisions will need to be made to prioritise some over others. IHPA should be explicit as to which of the principles are prioritised and which are given a lower priority. Further, the handling of outlying data should be justified.

We strongly support the need for administrative and operational feasibility as added complexity in data collection takes away from patient care, and all data collection needs to provide clinical value in addition to capture service usage.

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?**

In principle we agree with continuing to use a service event as a unit of count and agree that it should include multidisciplinary case conference activity as proposed for 18-19 Tier 2 classification as this is an essential component of delivering non-admitted complex rehab services in the community. However, we would still strongly encourage a broader definitional view of service event be considered, especially in

relation to capturing other essential non-client facing activities such as case planning. This would encapsulate the significant workload that occurs, such negotiating services on client's behalf, providing advocacy, scripting equipment, writing lengthy reports – all of which is significantly more time expensive compared to a single service event in a hospital based outpatient clinic. The nature of our statewide services requires clinicians to visit people in their home. Staff travel to appointments is currently not considered in the count, and while we recognise that IHPA would encourage technology such as telehealth to deliver services to reduce the need for travel, the reality is that for our services we must see clients in their home or the community.

The other key failing of service events for our services is that the duration of the service is not reported, however, the length of a service event is significantly more than a hospital based clinic appointment, which directly drives the cost of the service. We would advocate for the duration of the service event to also be captured and considered a cost driver rather than a simple count. This is not dissimilar to the current practice for Medicare billing for medical consultations recognising a higher payment for a longer duration patient attendance.

Currently service event counting only applies the multiple health care provider indicator when three or more clinicians provide a service. In the community, home visit setting when dealing with complex multifactorial issues, joint visits by two different clinicians from the same service are common. This provides efficient service to clients, joint collaborative decision making that potentially provides higher quality health care to the client. This type of service event is clearly more expensive to deliver, which is not currently recognised, and encourages gaming of the system by services splitting the service over different days to gain payment for the two discipline interventions. We believe the multiple health care provider indicator should apply for two or more clinicians, even if at a slightly lower rate than for 3 or more clinicians.

And finally, we would encourage IHPA to consider allowing a service event count for clients within a non-admitted episode when the intervention is provided to the client during an inpatient admission as they are reaching the end of the sub-acute admission or have short acute admissions during the community episode. The opportunity to stay actively involved in the client's care while in hospital should be encouraged and offers significant value in clinical handover and supports clients transition through the health settings, elements both considered essential in the National Safety and Quality Health Service Standards.

The Definition of a Service event is reasonable, however the definition "be provided by the patient in their own environment without the presence of a healthcare provider" will require greater qualification and should probably read "be provided ***to*** the patient in their own environment without the presence of a

healthcare provider" as there would appear to be some need for a sense of agency to meet the requirements of a "service"

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?**

An episode count may have relevance for short, procedural based interventions, however for client centred, complex care it is difficult to define an episode as there is great variability in the complexity and resource demand from one client to another. However there would certainly be some value in adopting an episode model if it significantly reduces the administrative burden of data collection for clinicians.

The discussion refers to episode as being "for a period of time" with example provided of 28 day service. While this approach may apply to non-admitted service with short periods of contact (the example of post- operative care, for example), it is not clear that this will be a useful model for those with more chronic conditions. It is more likely that other descriptors will be required to capture episodes with a class of resource utilisation. These may be related to the intent or goals of the clinical contact (particularly in the subacute care domain) with some form of functional measure describing status and progress (possibly within a time-limited framework)

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?**

There is a difference between patients with chronic diseases, such as diabetes, and clients with conditions/disabilities that impact on their health over their lifespan, however the complexities of identifying and capturing the different resource requirements are similar. If a separate path for classifying chronic disease was considered we would encourage that lifelong conditions and injuries are also captured in a similar manner. Comorbidities would still need to be captured in addition to a chronic disease or lifelong condition as people presenting with additional issues such as drug and alcohol and/or mental health significantly impact on the complexity and duration of care at an intervention and episode length level.

There has been a tendency in the past to ignore chronic disability in chronic disease frameworks.

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

Royal Rehab is like all other health providers and do not currently collect the diagnosis/presenting problem on admission (or throughout the long episode of care) in a format that could be extracted easily

for reporting. Given this will require modification to the current internal EMR a realistic timeframe to transition to this model may be three years or more.

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

Diagnostic dimensions should be beyond organ level descriptors. We suggest that reference be made to the WHO ICF model and consideration of Impairment, Activity/Participation level descriptors in some instances – possibly related to the goals of the intervention or service?

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

While a patient may present with a diagnosis of SCI or ABI, some clients may not present with significant "problems" at the time of admission, or there will be a significant but practical difference to the diagnosis and presenting problem e.g. patient diagnosed with SCI but presents with pressure injury and pain. The rehab models of care are currently built on the International Classification of Functioning Disability and Health (ICF) which provides a basis to work on client centred, goal directed care. The goals and resulting interventions are based on the key components of the ICF, being body function, activities and participation and environmental barriers. There are also many clients that present with several problems at admission e.g. pressure injuries, pain, seizures etc, however the type and severity of the presenting problems can change many times throughout the one episode of care. This would need to be accommodated in a diagnosis and problem based classification system to determine ultimate payment to the service provider.

The current presenting problem definition will be problematic across different clinician backgrounds, disciplines and level of expertise and likely to have substantial regional variation (Within currently existing classification schemas, for example with in the SNAP – the problems with GEM and Rehabilitation definitions are an example in point)

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?**

To fully understand the application of this initial list of presenting problems/diagnosis it would have been beneficial to demonstrate their use against a sample case study, perhaps also with application of the complexity variables. It is assumed that a client could be given a number of the presenting problem/diagnosis types from the same grouping (e.g. MDC 01 Nervous System – Paraplegia and Chronic Pain) and also from other groupings (MDC 09 Skin, Subcutaneous Tissue and Breast – Skin Ulcer, pressure injury). Currently the list is quite limiting for the range of presenting problems that often accompany an

SCI diagnosis. The list is also extremely restrictive for classifying brain injury as a presenting problem/diagnosis, only fitting with MDC 21 Injuries, Poisoning and Toxic Effects of Drugs.

The current list ignores issues that lead to the ANSNAP classification and WHO development of the ICF – please refer to the large literature in this regard. Given our community rehab models are based on ICF principles the proposed intervention-type groupings are rather procedural and not overly relevant to our services.

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?

Royal Rehab would support an approach that captures the whole patient journey and better reflects the costs of specialised multidisciplinary care. Generally we agree with the range of complexity variables currently listed, except that the other levels of description related to the WHO-ICF are not acknowledged. It is notable that consideration has been given to the concept of "new/repeat" visit stating that costs for a new visit was slightly higher than a repeat visit. However, for spinal injury as the number of years post injury increase clients experience what is anecdotally termed "ageing with a spinal cord injury" and often referred to as the "second injury" where they may consume equivalent or greater health care resources compared to their initial community rehab journey.