April 2018

Australian Non-Admitted Care Classification - Consultation

Silver Chain are one of Australia's largest providers of out of hospital health care. Our Health Division provides care to over 60,000 clients nationally performing over 1.2 million occasions of service in client's homes or in community based clinics. We provide health care in four clinical streams, Acute Care, Palliative Care, Wound Care and Chronic & Complex Care.

In conjunction with the National Casemix and Classification Centre (NCCC), Silver Chain has recently completed a clinical costing study using our existing corporate and clinical datasets to inform the formation of a new classification system for our health care activities. The new classification will assist in describing our client population in a more meaningful way, allowing us to demonstrate the complexity of the clients we provide services to and the efficacy of our models of care.

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

   Silver Chain agrees the new classification should support the delivery of care between settings. The classification should be relevant to hospital, community clinic and client's home settings and should focus on client characteristic. It is also very important that the classification is at least initially based on data elements that are currently collected, particularly by community based service providers. Because their information systems are very different to hospital patient admin systems, and often used by clinicians for primarily clinical purposes the system should acknowledge that changes will be required across the community based information systems to enable better integration of the classification and funding approach

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, the new classification should support new models of care by being agnostic to whether the client and provider are in the same physical location and agnostic to the modality of the service provision.

3. As the types of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes?

   In order to encourage innovation and development of services the classification system should focus on the client needs profile and complexity rather than the actual services to be delivered in non-admitted care. This will encourage flexible and innovative approaches to care delivery.

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?

   Silver Chain agrees with the classification principles as outlined.

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?

   Silver Chain agrees with continuing to use service event as the unit of count for the new classification and we support the use of the new definition. However, opportunities to capture and count non-admitted episodes of care should be explored and progressively implemented where this is feasible and clinically meaningful.

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?

   Silver Chain will continue to collect data at the service event level for all services provided. We do support consideration of using episode as a unit of count particularly in services such as palliative care. Silver Chain's newly developed community based classification system uses episodes as the unit of count, with each episode consisting of a predictable number of visits (and cost) within each class.

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?

   Silver Chain currently provides services to clients with chronic disease in partnership with Western Health in Victoria under the HealthLinks program. Consideration should be given by IHPA to ensuring the ANACC system should classify these types of programs separately. Episodes of care in these types of programs may extend for many years making them difficult to classify in a meaningful way compared to more acute non-admitted service provision. Our work with the NCCC has shown for these types of clients it is possible to design a classification system that allows for concurrent episodes of care with different goals of care for each episode. Under our working definition, an episode of care is defined as "the period of time in which an organisation provides a service (*product*) to a person in the community, for which there is a specific *goal of care"*.

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

   At least two to three years-recognising the need to modify some information systems that are integrated with care delivery and reliant on clinical staff for data collection.

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

   For NGOs that provide health care services in the community on behalf of public health care organisations, the data sets currently collected usually reflect contractual requirements in the first instance. Diagnosis data may not be present on referral of clients to these services and with few clinicians available who are able to make diagnoses in the community sector it is preferable to use the "presenting problem".

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

    Silver Chain agrees with using the "presenting problem" as the diagnosis type variable and the definition proposed. Importantly, there should be capability within the system to capture multiple 'problems' which informs complexity analysis and classification development.

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?

    Silver Chain agrees with the proposed list of presenting problem/diagnosis type and intervention groups. Refinements that IHPA should consider include: Although these are an aggregated version of diagnosis-types it would be useful to have subgroups of diagnosis types within each MDC that may be used for analysis purposes. (for example, in the Gastrointestinal system these could be neoplasm, functional conditions and inflammatory conditions.) It would also be very useful to identify acute vs chronic diagnosis 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?

    Silver Chain agrees with the list of complexity variables. However, we believe other client centric variables should be considered including whether the client lives alone and whether they require an interpreter. Both of these variables may impact in a material way on the cost of each intervention provided in a client's home.