Response to Public Consultation on the Development of the Non-Admitted Care Classification by SA Health

South Australia agrees that the current Tier 2 classification system for non-admitted services is not ideal and a new classification is required, one that is focused on the patient rather than the proverbial "name above the door". While the gold standard is what everyone will be aiming for there needs to be a pragmatic approach initially as to what is deliverable in the short term compared to where we would like to be in 10-20 years time.

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

South Australia believes the new classification should support the delivery of integrated care between health care settings. In order to transition patients between care types there needs to be the ability to document the diagnosis and treatment history of the patients, and have the ability to map similar care and patient types to assist with future service provision. We feel the crux of integrated delivery lies within accessible, comparable and understandable patient data which can be utilised by a varying number of health professionals and administrators. We agree that electronic health records such as MyHealth will be a great tool in allowing access to current patient data, but have reservations about the database's security and doubts over whether we can overcome the challenges faced with retrofitting a database which has been developed for mainly administration and limited purposes.

In saying this, implementing an electronic health record database has significant benefits, where the mapping of a patient's history will improve health trend analysis (such as accurate measurements of specialist wait times), reduce complexities through documentation of comorbidities, and increasing comparability of patients in similar diagnosis related groups across different health settings. Mapping the patient's care, treatment and diagnosis history will allow for a greater measurement of patient outcomes, thus, allowing for greater analysis and implementation of high value care, because good patient outcomes are a fundamental in delivering health care.

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

The essence of the new classification should be that it is not reliant on technology, but flexible and consistent across different service settings. The use of technology should only assist and enhance the implementation, adaptation and functionality of the new classification system. For example the adaptability in the system could come from flexible numbering and sequencing to allow for additional services and technology to be incorporated as required, similar to the current AR-DRG classification and the proposed emergency care classification. The aim is to develop a classification system that maintains a consistent structure that does not vary significantly while enabling changes in care to be accommodated within the categories and complexities.

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?

One of the biggest challenges in this area is the ability to provide the most appropriate care in a timely manner, in the best place for the patient that is cost effective. The concept is simple but the implementation is fraught with hurdles. As some of these hurdles are not known until they come to fruition prevention is not always possible. To this end the classification system needs to have flexibility, as described in Question 2, so that the changes can be incorporated without impacting the stability of the classification significantly.

Further comments suggested that the new classification could be used in a way to identify, over time, low value care that should potentially be phased out. At the moment these types of care are hidden behind the proverbial "name above the door".

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?

The classification principles are appropriate and agreed with. However, we suggest paying close attention to the clarity and consistency of the classification system, in order to ensure the data is of great quality and transparency for users. It is believed that if this is achieved, the completeness, timeliness and accuracy of patient classification data will also be improved, which will reduce the burden of increasing data quality work for administrators of data collection. We also strongly agree that the classification system needs to be patient based, not clinic based, because activities in the one clinic can vary from another with the same name (Tier 2).

The principles should also consider the readiness and capability of jurisdictional systems, and include education of the clinicians so they are aware of what the new data capture requirements are trying to achieve and how it will benefit them.

In terms of 'administrative and operational feasibility', it is advised that the classification system and data collection for non-admitted patients is not the same as for admitted patients. Purely because the coding workforce infrastructure currently utilised by health services will not be able to shoulder the added load of coding for non-admitted patients, due to low employee numbers and the additional education that will be required.

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?

Initially it is in the best interest of the system to keep the unit of count as close to the "service event" definition as possible. A new classification system will bring with it many changes therefore keeping the basic unit count stable to start with is preferable while other areas are being developed.

Going forward a balance will need to be struck between what is possible within the available systems and what is gold standard. For example the multi-disciplinary case conferences

where the patient is not present, while very useful to understand resource utilisation does not necessarily provide great clarity in cost allocation, especially when it is difficult for a number of sites to differentiate this type of activity at the moment.

Once the basics of the new classification are bedded down there is definitely scope, and from a commissioning view a need, to look at other ways to count activity. Bundling service events in, say, rehabilitation would give providers greater scope to innovate with their programs but this must be tempered with the ability to count accurately.

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?

In line with above, South Australia feels that an episode of care should not be considered as a unit of count initially in the new ANACC, we would like to see a focus on the current service event unit of count before focussing on other opportunities, especially seeing as the current classification overhaul will already see a change in practice. In saying this, the benefits of episode counting has been acknowledged, specifically for some conditions with more defined episodes of care or where start/finish points for an episode can be suitably established (such as Acute Elective Surgery). As well as being able to account for care provided across sectors and care settings.

Some of the concerns with episode of care as the unit of count are the lack of clarification on episode start and end points, and whether a new episode is triggered with complexity, more than one condition or another diagnosis? What if the presenting problem is not in fact the actual medical issue and the patient requires different treatment? What is classified as an episodic unit or patients with variable treatment regimens? How flexible will the unit of count be if the patient has complications (e.g. a torn hamstring while rehabilitating a knee reconstruction, increasing the length of episode and resource utilisation)? Is there incentive for clinicians and health professionals to under service their patients? Will the episode of care meet our needs for patent specific data?

We would like to see it implemented in the future after understanding the future implications and benefits of the episode of care counting system and realising its viability.

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?

The need for a separate path for chronic disease patients should not be considered in the first iteration of the new classification given there will be data collection issues in adequately identifying these patients initially. The South Australian view is that chronic disease and comorbidity is of interest across all health care settings, not just non-admitted, because of the different resource requirement of these patients. The chronic disease management model may improve the identification of such patients, but an electronic health record system will allow patients with existing conditions and chronic disease to be flagged/identified in order to develop the best treatment strategy possible. This data can then be used to assist the future development of chronic disease and comorbidity treatment strategies, to

determine paths of increased efficiency and improved health outcomes. The improved treatment of patients with chronic disease and comorbidity should lead to the reduction of re-admissions and the decrease of more complex diagnosis, thus, reducing the strain on the public health system.

As stated in Question 4, we strongly advise that the patient data input for electronic health record burden should not fall on the current inpatient coding workforce, due to the large scale of work load involved with non-admitted patient information and further education requirements with the new system.

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

Because of the uncertainty surrounding the magnitude of the changes caused by implementing the new classification system, South Australia is unsure what timeframe will be required for jurisdictions to transition to a patient-based non-admitted care classification system. The expected complexity of a new electronic patient administration system and delays in the amendments to current processes and systems would push the time frame to two years minimum. Time consuming factors such as distributing additional resources, increased education and training, revised collection management and quality assurance, new reporting systems and procedure changes make it difficult to predict how long it would take to implement. Until we know more, we can only speculate.

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

If a diagnosis type variable is included in the future classification system, it must be simple, meaningful, sustainable, intuitive and easy to adopt, requiring minimal resource utilisation and limited further education.

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

'Presenting problem' is indicative of resource use and therefore funding around this classification is likely to be reasonable. But for a long time, one of the challenges with 'presenting problem' as being the diagnosis type variable has been the 'point of view', where clinicians have previously had differing views of classifications through the subjective nature of a diagnosis. There is currently no national definition of 'presenting problem' and it has been difficult to find an agreement on a definition. The proposed definition "the problem that the patient presents with to the non-admitted service, as determined by the clinician first assessing the patient" is determinative, but of course, is open to subjectivity. This means a nationally recognised 'term list' needs to be agreed upon, implemented and continually updated for 'presenting problem' to be a consistent and reliable diagnosis type variable

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?

Initially the proposed list looked like a reasonable starting point for the non-admitted classification however after reviewing the emergency care diagnosis list some issues have come to light. For example for some ailments there are multiple "presenting problems" that could be used, like fractures. In other examples there seems to be a lack of guidance as to where they go, for example palliative care. While we do need to get away from the "name above the door" type classification the proposed list still has a very strong element of that in there.

The move away from the MDC/DRG type structure made the emergency care classification less confusing and the same principles should be adopted for the ANACC. In the end whatever structure is used it needs to be explainable to those that use it and robust enough to not change significantly when the refinement of the classification occurs.

There were concerns raised about the proposed interventions, and while we accept this as face value it is not for administrators to determine what is appropriate, clinicians would be able to provide more robust discussions on what is necessary. That said it would be preferable for the new ANACC to be adaptable at a local level as system administrators are interested in more granularity, for example type of gastroenterology endoscopy, than may be required for classification and pricing.

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?

South Australia agrees with the list of complexity variables presented however notes that until full analysis is conducted it is not possible to determine if the variables listed relate more to patient complexity or are better off being used for pricing. Feedback indicated that stakeholders see remoteness and indigeneity as complexity variables but in other categories they are used more to determine pricing than complexity of the patient.

As with emergency care where did not waits and left at own risks are priced it is felt that "failed to attends" should also be included as there is a need to understand the volume of these service events, as the classification is not only for funding but also for understanding resource allocation.

Initially it may be preferable to have chronic disease as a complexity variable, that way implementation of the separate pathway can be introduced to the system in a structured way to ensure as much stability as possible.