IHPA Stakeholder Consultation Paper - Australian Non Admitted Care Classification Development

Consultation Questions	Comments/Response
1. Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?	Yes. The new classification will require information systems to be flexible and transportable across treatment settings. It should include common linkable variables between various health care settings and sectors. Pricing must be cognisant of the potential for the creation of perverse incentives between providers and/or settings.
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 current dominant fee-for-service models and classification system that underpin them does not encourage co-ordinated care of people or disease management. The new classification needs be flexible and 'follow the patient'. The classification system will require the ability to reflect all key clinicians activates (Medical, Nursing Allied health etc.). The new classification should include a population dimension (enabling the identification of population clinical characteristics and resource requirements). Similar to the issues identified as pre-conditional to introducing 'bundled pricing for maternity', the new classification needs to utilise a common single patient identifier that enables linking of all modes of integrated non-admitted care between health care settings/providers to the individual patient. The ANACC should support the better alignment of the price across settings.
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?	The new classification system will need to be agnostic of settings and sectors. Enabling the identification of the same activities whether they occur in the Home (residence), Community or Hospital and include services of that are out-reach and in-reach in nature. The classification system should derive the "boundaries" not the setting.

	The classification needs to utilise the current data collections from various health care settings. There is currently no uniform clinical coding of non-admitted care in the community, primary and sub-acute sectors (similar to that of acute admitted care). This would require high levels of training and resourcing.
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?	Agreed as a good starting point.
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? Howcould it be improved?	Agreed as a good starting point, but there should be the ability for development of a dimension for the Episode of care (Treatment, disease and time based).
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?	Yes. Episode of care would enable 'bundling' of a number of specific conditions ie. cancer, orthopaedics, maternity, other chronic conditions.
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 new classification needs to be flexible enough to identify these groups of patients. It would be useful to include a 'phases of care' approach for classifying chronic disease patients.
8. What implementation timeframe is required for jurisdictions to transition to a patient- based non-admitted care classification system?	Phased roll out over 5 years for ABF sites. Similar to the implementation of AN-SNAP for sub-acute and non-acute patients, there will need to be a default classification system used in the interim if sites cannot implement the ANACC system; especially smaller rural faculties.
9. What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?	The classification needs to be a wholistic and flexible approach that respects all clinician interventions and patient treatments to enable mapping between various systems (similar to the mapping of Sno-med to ICD 10).
10. Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of 'presenting problem'?	Yes. Agree to the proposed definition of 'presenting problem'. Do not support the use of the wording in the definition - 'the problem that the patient presents with to the non-admitted service as determined by the clinician first assessing the patient' – as this is limiting the scope, there may be medical, allied health and nursing with differing presenting problems recorded.
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	Agree to the proposed MDCs listings, as this will also enable comparison with the acute admitted setting. Will the listings align with the AIHW chronic

considered?	conditions groupings?
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 with the complexity variables. The current Tier 2 classification is not truly descriptive of the care and treatment provided. An additional variable may be the development of a 'phase of care'.
Other Comments:	Page 27 – third dot point (under Section 5.2.1 Data analysis to inform future variables) states *"Four diagnosis chapters of the ICD-10-AM capture 65.5% of the costing study activity, and therefore a candidate classification system that adopts diagnosis may only need to include a selected scope of diagnosis instead of the entire range".* Disagree and that all chapters in the ICD-10-AM need to be included otherwise it poses limitations on the expansion of the diagnosis. Just using ICD 10 limits the scope of describing the services provided.