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Mr James Downie
Chief Executive officer
Independent Hospital Pricing Authority
PO Box 483
Darlinghurst NSW 1300

Dear James

Re: Submission to the Independent Hospital Pricing Authority on the Draft Australian National Subacute and Non-Acute Patient (AN-SNAP) Classification Version 5.0

AHSRI welcomes the opportunity to provide feedback on the draft AN-SNAP Classification Version 5.0. AN-SNAP was first developed more than two decades ago by the Centre for Health Service Development (CHSD), a research centre within the Australian Health Services Research Institute (AHSRI), University of Wollongong. Ongoing refinements of the classification were undertaken by CHSD up to and including Version 4.0.

It is interesting to note that given the significantly larger number of records available for the development of Version 5.0 only minimal changes are proposed, resulting in only a 0.4 per cent improvement in RID. This is reflective of the robustness of the AN-SNAP classification, but also highlights the ongoing deficits in the collection of variables that could impact on costs in some classes.

Inclusion of a frailty variable

The principal change proposed for Version 5.0 is the inclusion of a proxy measure of frailty. While AHSRI supports the addition of a patient frailty measure to test as a potential cost driver, we do not support the implementation of the frailty risk score tool. The measure has been proposed for inclusion in only the GEM and non-acute care types and not rehabilitation as the retrospective approach to data collection compromises the utility of the classification, leaving the selection of a standard measure of frailty that could be used consistently throughout the AN-SNAP unresolved. There are also concerns around the tool that has been proposed.

Measuring frailty

While there is agreement that frailty as a cost driver should be investigated for inclusion in AN-SNAP, there is no data currently available in the national data set and IHPA has reported that there is no consensus around a frailty measure that could be used - thus leading to the proposal to use ICD codes as a proxy for frailty.

The recent work that AHSRI has undertaken for the Commonwealth in the development of the Australian National Aged Care Classification (AN-ACC) for residential aged care funding includes important ideas regarding the cost drivers that relate to care needs (care costs) and the use of a range of assessment tools. These concepts could be applied to improve performance of the GEM and non-acute care types. The AN-ACC assessment and classification was informed by expert clinical advisory panels comprising over 30 clinicians and researchers. The experts agreed that frailty, among other variables, was a key determinant of care costs in residential aged care. There was consensus on the selection of seven standardised instruments and other items to measure the range of identified variables, with the Rockwood Clinical Frailty Scale, along with questions around falls and weight loss, included as a measure of frailty. The assessment tool has been rigorously tested, including as part of the AN-ACC development research study and also in a successful field trial of the tool by the Commonwealth. It is now being used by a trained workforce in a 'shadow' assessment period of aged care residents nationally, prior to government finalising a decision around implementing AN-ACC for funding residential aged care in Australia[1].

AHSRI recommends testing the introduction of a standard frailty measure as a prospective measure that is captured at the beginning of each GEM and non-acute episode. By definition, every GEM/non-acute patient is at risk of frailty, and it is important to determine that a frailty measure discriminates between patients in terms of their relative need of care. This would also inform the inclusion of frailty into the rehabilitation branch.

The utility of the AN-SNAP classification

A feature of the AN-SNAP classification is that the data collection is prospective. Measuring patient frailty at the start of the episode retains the utility of the classification - as the AN-SNAP class can be assigned and used for clinical management purposes, such as planning length of stay and care goals. More than 250 hospitals in Australia currently provide AN-SNAP data to the Australasian Rehabilitation Outcomes Centre (AROC), AHSRI. This data collection has been ongoing for more than 20 years and is used to develop the national benchmarks for rehabilitation care that informs care planning and drives ongoing quality and improved processes and outcomes in subacute care.

The inclusion of a variable that is collected post-discharge results in the classification losing its clinical functionality. The Rockwood can be administered in around five minutes and provides information to support care planning and delivery during a patient's subacute episode.

Other limitations of the frailty risk tool

The proposed frailty risk score tool was developed for use in the acute care setting to flag patients at 'risk' of frailty and plan their acute care accordingly. Risk factors for frailty in acute care may not be the same as risk factors in subacute care, and the list of ICD codes may not be representative of those characteristics related to frailty that discriminate between patients' use of resources in the subacute setting. While the exclusion review has been undertaken to remove codes considered to be extraneous, this has not addressed the issue around the omission of codes from the list that could be important indicators of frailty in the subacute/non-acute care setting.

A further consideration is that when the tool is used for the purpose it was designed for in the acute setting, the frailty risk score is calculated by accumulating all the codes assigned across all of a patient's previous acute episodes, thus drawing on a comprehensive medical history to formulate their risk of frailty. When applied as proposed, the documentation for an individual sub-acute episode may not provide sufficient clinical information to accurately determine a patient's frailty status.

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[1] Refer www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/residential-aged-care-funding-reform (accessed May 2021)

Issues around documentation could particularly disadvantage standalone extended care and subacute facilities, with hospitals that provide subacute care as well as acute care potentially doing much better.

Future development

AHSRI looks forward to being involved in the ongoing development of AN-SNAP. Our national data collections can be utilised to investigate potential variables and measures for collecting new data items and will be particularly useful for the future work that IHPA has flagged for palliative and paediatric care types.

Yours sincerely

Ms Carol Loggie

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