SA Health response to IHPA Consultation Paper on Australian National Subacute and Non-Acute Patient Classification Version 5.0

Response Overview

South Australia appreciates the opportunity to provide feedback on the Independent Hospital Pricing Authority (IHPA) Draft Australian National Subacute and Non-Acute Patient Classification Version 5.0 Consultation Paper released on 12 April 2021.

SA Health has developed the following response through consultation with stakeholders in the Department for Health and Wellbeing (DHW) and the Local Health Networks (LHNs)

Responses to the consultation questions are summarised in this submission.

Consultation Questions

Do you support IHPA's proposed approach to use the Frailty Risk Score calculated from ICD-10-AM codes as proxy markers of frailty? If not, why not?

The generalised response from LHNs agree frailty is a cost driver and support the Frailty Risk Score (FRS) as a valuable tool to support decision making.

However, it was suggested consideration be given to the coding process where coders may be restricted by coding standard ACS 0002 Additional diagnoses which results in an over reliance on medical officer documentation in progress notes to support criterion for code assignment.

This has become apparent in the dementia/delirium axis which similarly requires coders to make classification decisions. Despite nurses filling in MMSE and OTs filling in a MOCA or RUDAS coders still look for medical officer documentation in progress notes to support the classification of dementia or delirium.

If the Frailty Risk Score is adopted for AN-SNAP V5, do you support IHPA's proposed approach to exclude less defined and redundant codes from the score's calculation? If not, why not?

There is support for the approach to exclude redundant codes, however another made the recommendation the ICD-10-AM exclusion lists be reviewed as they are not reflective of clinical resource use in care setting for example:

1. In the frail elderly, even a superficial injury of the head (S00) or superficial injury of lower leg is likely to have a significant impact on outcomes and therefore, a cost driver. There is less of an issue with the codes relating to the context of falls.

2. It can be difficult in the frail to classify exactly the cause of the dysphagia and therefore, question whether R 13 should be excluded.

For future work (i.e. beyond AN-SNAP V5), do you prefer any particular prospective frailty instrument being prioritised by IHPA for further investigation (including potentially being proposed for the admitted subacute and non-acute hospital care national best endeavours data set)? If so, why? Examples of the type of instruments include but are not limited to:

- *the Rockwood Clinical Frailty Scale*
- *the Australian National Aged Care Classification (AN-ACC) assessment tool*.

LHNs support the use of The Rockwood Clinical Frailty Scale (Rockwood) - given that this is already extensively used by clinicians and FRAIL-NH (Kaehr E et. al. JAMDA 2015; 16(2):87=89.) described as an easy to use screening tool with validation conducted in Australian studies (relating to residential aged care) and easy to implement in clinical practice.

The Australian National Aged Care Classification (AN-ACC) assessment tool was not supported describing it as better used on residential aged care rather than the health system.

Do you support IHPA's proposal to establish a new impairment type group Orthopaedic conditions, replacement for knee, hip and shoulder replacement activity?

There were limited responses to this but there is support to establish this new impairment type group.

Do you support a measure of frailty being introduced into the classification for adult admitted rehabilitation care, in principle? If so, do you have an approach you recommend?

Support was given to the current system working well, noting the frailty score would not work well with younger populations (people under 70) and may distort the approach to care for many people.

However, it was noted a frailty measure may be of benefit for the reconditioning stream and for the orthopaedic fractures stream in understanding the impact of frailty on complexity and LOS.

Do you have any suggestions for future work to refine the classification of adult or paediatric admitted palliative care such as:

- *care cost drivers which could be further investigated; and/or*
- *data items to consider for national collection?*

Given the Frailty Risk Score outperformed the Resource Utilisation Groups – Activities of Daily Living (RUG ADL) for maintenance care this may be worth exploring for palliative care, given the substantial proportion of patients with frailty who are complex and likely to be a significant cost driver.

Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the GEM care type? If not, why not?

Feedback from LHNs are supportive of the proposal to introduce the Frailty Risk Score.

There is support for the removal of the dementia/delirium flag as it is captured in the FRS and agrees the FRS should be the primary driver of the first split followed by Functional

Independence Measure (FIM) motor. However, there were questions about the fact that FIM can also be considered to measure a level of frailty.

Although, another LHN is concerned the frailty score has displaced the dementia/delirium measure. Given the Geriatric Evaluation and Management Units (GEM) experience that dementia is a major driver for cost, complexity and LOS. There is concern that this may be lost or watered down by the introduction of a more generalised frailty measure. A preferred approach would be to use an existing frailty measure such as Rockford alongside an existing dementia score such as Mini-Mental State Examination (MMSE).

Do you have any suggestions for future work to refine the classification of GEM care such as:

- *care cost drivers which could be further investigated; and/or*
- *data items to consider for national collection?*

There is concern dementia is a significant cost driver and if this is largely removed there is a risk that the frailty measure alone will not support an understanding of costs.

The dementia variable as a stand-alone variable has been very strong in explaining the issues that face out GEM.

Challenge with frailty indices – fail to differentiate between frailty, disability and comorbidity. Note studies done well predicting resource use although not sure did so well in terms of outcomes, readmission and mortality.

Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the non-acute care type? If not, why not?

General consensus amongst LHNs is this will be a viable solution agreeing measuring frailty would be more predictive of length of stay and cost of admission.

The challenge with frailty indices or scoring tools however is that they fail to differentiate between frailty, disability and comorbidity, which is a spectrum and therefore hard to be a foolproof predictive method.

The move towards adding frailty measurement in predicting cost is a move in the right direction.

Do you have any suggestions for future work to refine the classification of non-acute care such as:

- *care cost drivers which could be further investigated; and/or*
- *data items to consider for national collection?*

The major driver for long length of stay (LOS) among this client group is dementia/delirium and in particular challenging behaviours.

The ability to place this client group within a residential aged acre facility is problematic and so drives the LOS.

Introduction of a standalone dementia measure may be of value, but could not be achieved alongside the frailty measure.