SESLHD Responses to IHPA SNAP Classification Version 5.0 Consultation Questions	
IHPA Item 3.6.2 Patient Frailty Consultation Questions	**SESLHD Response**
1) 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?	1) We do not support IHPA's proposed approach to use the Frailty Risk Score calculated from ICD-10-AM codes as proxy markers of frailty for any Subacute Care Type (Rehabilitation, Palliative, Geriatric Evaluation and Management, Psycho-Geriatric and Maintenance). This is because IHPA's proposed approach it is dependent entirely on the use of retrospective ICD-10-AM clinical coded data that is assigned by Clinical Coding Departments after the patient has been discharged from hospital and is not completed in real time by health professional caring for our patients and therefore does not inform real time clinical care delivery and does not inform real time clinical decision making.
2) 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?	2) We do not support IHPA's proposed approach to exclude what IHPA deems to be "less defined" and "redundant" ICD-10-AM codes when calculating the Frailty Risk Score. This is because whichever ICD-10-AM codes IHPA deems to be "less defined" and "redundant" in relation to frailty will create a selection bias in patients selected for calculation towards the Frailty Risk Score as it will capture a certain cohort of patients and will exclude frail patients who may have less complex conditions or "less defined" conditions/codes which are documented by the treating clinician. Furthermore frail patients with less complex conditions are a clinical occurrence as they are well documented in the medical records by the treating clinician and form a large cohort of the patients treated and by excluding them creates the risk of not including such patients towards the calculation of the Frailty Risk Score and the SNAP Classification Version 5.0 which will reduce our ability to examine their clinical profile, associated costs, outcomes and service needs.
3) 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	3) The RockWood Clinical Frailty Score is the preferred prospective frailty instrument to use as it is completed in real time which informs real time clinical care delivery and real time clinical decision making. Furthermore our Subacute Clinicians are already aware and trained to use the RockWood Clinical Frailty Scale.
IHPA Item 4.2.1 Rehabilitation Consultation Questions	**SESLHD Response**
1) Do you support IHPA's proposal to establish a new impairment type group Orthopaedic conditions, replacement for knee, hip and shoulder replacement activity?	1) We do support IHPA's proposal to establish a new impairment type group for Orthopaedic Conditions (Replacement for Knee, Hip and Shoulder Replacement) as it provides further specificity to the Orthopaedic conditions that are treated and will also assist to stratify such patients further into their respective financial classifications for future analysis as orthopaedic patients are seen increasingly in the private sector.

2) 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?	2) In principle we do support a measure of frailty for being introduced into the classification for adult admitted rehabilitation care as frailty does impact clinical care and outcomes. The approach would be to use the existing RockWood Clinical Frailty Scale which it is completed in real time by health professionals and informs real time clinical care delivery and real time clinical decision making.
3) Do you support IHPA continuing to explore the Functional Independence Measure for children (WeeFIMTM) as a potential variable within the paediatric rehabilitation classes? If not, why not?	3) We do support IHPA's efforts to continuing exploring the Function Independence Measure for Children (WeeFIMTM) as a potential variable within the paedriatric rehabilitation classes noting that WeeFIM is currently not collected in the Subacute Data Collection and AROC holds the licencing, certification and training of the WeeFIM Tool.
4) Do you have any other suggestions for future work to refine the classification of adult or paediatric admitted rehabilitation care such as:	4) Nil
• care cost drivers which could be further investigated;	
• and/or data items to consider for national collection?	
IHPA Item 4.2.2 Palliative Care Consultation Questions	**SESLHD Response**
1) Do you have any suggestions for future work to refine the classification of adult or paediatric admitted palliative care such as:	1) Nil
• care cost drivers which could be further investigated;	
• and/or data items to consider for national collection?	
IHPA Item 4.2.3 Geriatric Evaluation and Management (GEM) Consultation Questions	**SESLHD Response**
1) Do you support IHPA's proposal to introduce the Frailty Risk Score as a variable for the GEM care type? If not, why not?	1) We do not support IHPA's proposal to introduce the Frailty Risk Score for the GEM Care Type. This is because it is dependent entirely on the use of retrospective ICD-10-AM clinical coded data that is assigned by Clinical Coding Departments after the patient has been discharged from hospital and is not completed in real time by health professional caring for our patients and therefore does not inform real time clinical care delivery and does not inform real time clinical decision making.
2) Do you have any suggestions for future work to refine the classification of GEM care such as:	1) We do not support IHPA's proposal to exclude Delirium and Dementia ICD-10-AM codes for GEM patients and replace them with the Frailty Risk Score. Delirium and Dementia make up the bulk of our GEM patients who are frail and are often the determinants of their length of stay so removing Delirium and Dementia would not be clinically representative of GEM patients.
• care cost drivers which could be further investigated;	2) Nil
• and/or data items to consider for national collection?	
IHPA Item 4.2.4 Psychogeriatric Care Consultation Question	**SESLHD Response**
1) Do you support IHPA's proposal to adopt the HoNOS 65+ total score to split short stay overnight episodes in the Psychogeriatric care type?	1) We do support IHPA's proposal to adopt the HoNOS 65+ total score to split short stay overnight episodes in the Psychogeriatric care type.

IHPA Item 4.2.5 Non-Acute Care Consultation Question	SESLHD Response
1) 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?	1) We do not support IHPA proposal to introduce the Frailty Risk Score for the Non Acute Care Type (Maintenance) and do not support the removal of RUG-ADL. This is because it is dependent entirely on the use of retrospective ICD-10-AM clinical coded data that is assigned by Clinical Coding Departments after the patient has been discharged from hospital and is not completed in real time by health professional caring for our patients and therefore does not inform real time clinical care delivery and does not inform real time clinical decision making.
2) Do you have any suggestions for future work to refine the classification of non-acute care such as:	2) Nil
• care cost drivers which could be further investigated;	
• and/or data items to consider for national collection?	