National Allied Health Classification Committee

IHPA Non-admitted care costing study - Public consultation May 2019

Response from members of the National Allied Health Classification Committee

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1. ***What changes to the scope of the study, should be considered?***

   Public hospital-employed Allied Health clinicians practice independently or as part of integrated and multidisciplinary teams across multiple non-admitted settings including outpatient clinics (discipline specific and multidisciplinary, both public and MBS bulk-billed with local funding arrangements), community rehabilitation facilities, community health centres (i.e. outreach clinics), community and hospital gyms and pools, workplaces, and in patients' homes.

   Block funded programs exist in jurisdictions, such as the Health Independence Program in Victoria, which includes services such as post-acute care, sub-acute ambulatory care services, specialist clinics and hospital diversion programs to assist patients transition from hospital care to home.

   Clarification is needed from IHPA whether all these activities are in scope.

2. ***In what ways can the selection/ feasibility criteria for sites to participate in the study be clarified or improved?***

   No further comments at this time

3. ***What other aspects of coordination of the study at the site-level should be considered?***

   A standardised position description and role statement from IHPA would assist hospitals recruit a site coordinator with the required experience and skills to successfully perform in this integral role. Engagement with key clinicians and clinic leads is essential

   Sites may find coordination more manageable if clinics that operated on different days across the week were targeted for recruitment, so support was readily available for staff.

4. ***What are the issues in collecting primary data (Part B: Primary data) for a period up to two months? Are there strategies that could be employed to keep clinicians motivated to collect data accurately?***

   Strategies to engage and motivate clinicians include the provision of a "what's in it for me" one-page information sheet from IHPA for participants outlining the expected time impacts, project support, local data input requirements and highlighting the longer term benefits to patient care, data quality, hospital systems and financial sustainability.

   Presenting Condition(s) and interventions can vary from clinic appointment to appointment & not necessarily be consistent across all appointments in an Episode of Care (EoC). Hence this/these data elements will be collected at each appointment but the previous session(s) values should be available to treating clinicians as a reference and potential time saver.

5. ***What issues should be addressed to ensure collection of data on a mobile app will be acceptable for health services and clinicians?***

   Issues such as adequate local Wi-Fi capability, communication of data-charges, enabling use of project rather than own devices for those who ask should be addressed.

6. ***What are other ethical issues that should be considered for the study?***

   Highlighting that clinicians are also free to withdraw from the study without consequence. Time burden should be minimised by pre-populating data fields where available. Use (or not) of local incentives such as small gift card or similar at completion of study.

7. ***Are there any unnecessary data elements on the list in Table 1? Why are they unnecessary?***

   No further comments at this time

8. ***Are there any data elements that are not on the list in Table 1 that should be included (i.e. features of patients/ service events that are likely to impact the cost of the care delivered to a patient)? For what reasons should these be collected in the study?***

   The concept of having a chronic or complex condition marker (in addition to presenting condition/s) could help explain why some Episodes of Care can last longer than others. For example:

   - People living with a disability: intellectual, physical, mental health issues, sensory deficit (blind, deaf).
   - people living with psychosocial conditions: impaired cognition, drug & alcohol abuse, financial insecurity, poor living arrangements, family violence, anxiety disorders etc

   ATSI status

   Postcode of residence (patients attending from out of area may impact the cost of service events through increased time taken to avoid repeat visit)

9. ***What clarifications or enhancements can be made to the definitions and/ or values of the proposed data elements in*** *Error! Reference source not found.**?***

   "Presenting Condition" is a suitable term to use as a synonym to "Allied Health Diagnosis". There will be some education required so clinicians understand the difference between what a patient has been referred for (sometimes this can be a minimal as "TKR" for a patient post-total knee replacement) & what their presenting condition is (pain management, reduced joint range of motion, etc).

   New problem ~~(less than 3 months onset)~~ as waiting time for clinic appointment may be longer than 3 months

10. ***The short list of primary presenting conditions is provided at Appendix A. Does the list capture the range of conditions encountered by each non-admitted clinic type that might be relevant for a patient-level classification of non-admitted care?***

    Responses below relate to additions to Handout 1 : IHPA ANACC presenting conditions shortlist as distributed at the NAC costing study National Workshop 3 May 2019.

    - "Muscle atrophy" &/or "Deconditioned" should be considered as they are encountered in allied health (post ICU admission or post long-stay admission).

- "Unable to determine" to cover scenarios where the patient doesn't attend their first appointment
- Chronic Pain Syndrome
- Expand types of Diabetes Mellitus
- Acquired Brain Injury
- Poliomyelitis

11. ***The list at Appendix A is also being proposed for secondary presenting conditions. Is the list appropriate to use towards determining the complexity of patients for the classification?***

    Comorbidities add to patient complexity. It is not unusual for patients to have more than 2-3 comorbidities impacting on their presenting or primary condition. Variation in the application of this data field is expected without clear guidelines for participating clinicians.

12. ***Appendix B provides a list of interventions that will be specified for the study. Is the list sufficient to capture differences in costs between patients treated in non-admitted settings? Are there any changes that should be made to the list?***

    Responses below relate to additions to Handout 2 : IHPA ANACC Interventions shortlist as distributed at the NAC costing study National Workshop 3 May 2019.

    - "Limb mobilisation" - "Joint mobilisation (including manipulation)" is a more appropriate term as not all joints are in the limbs (e.g. spinal mobilisation, temporomandibular joint mobilisation).
    - "Electrotherapy" or "Electro-physical Therapy"
    - "Ergonomic Advice" (i.e. educating the patient on how to perform their activities of daily living – including their work).
    - "Education" (e.g. a pre-admission clinic to describe what will be happening during planned surgery; or educating the patient about changes to their body caused by chronic pain; or critical information to prevent them exacerbating their condition; or educating a patient about diet and/or lifestyle so they can self-manage their chronic condition). Includes "Smoking cessation" or could this be a separate intervention
    - "Rehabilitation" (e.g. a program of exercise to aid physical recovery)
    - "Did not attend" or "Unable to attend" to cover scenarios where the patient doesn't attend their appointment.

- "Feeding tube procedures" to cover preventative care, removal and replacement of feeding tubes (including gastrostomies) by doctor, nurse or dietitian (06-006)?
- "Initial gastrostomy feeding tube insertion" (in endoscopy or radiology settings by a medical practitioner) would incur higher costs
- "Stoma site procedures" to cover preventative skin care and wound/skin granulation care provided to patients with ostomies or feeding tubes (06-002)?
- Social work interventions are rarely linked to ICD-10 AM or DRG assignment – consider the inclusion of interventions such as bereavement care, crisis intervention, family violence, elder and child abuse interventions, guardianship orders, providing accommodation and financial assistance

13. ***Can the data elements listed for primary collection be collected accurately and reliably by clinicians? If not, can additional guidance be provided to support accurate and reliable collection?***

Clarification is needed for participating clinicians that the "Presenting Condition" can be determined after the Intervention as sometimes it isn't until after performing some assessments that you can best understand what the presenting condition is or what the primary presenting condition is (and sometimes it will be the patient's own goals which will determine the priority of the conditions to treat).

14. ***Are there any additional sources of secondary data that should be specified?***

The following Allied Health National Best Practice Data Sets (NBPDS) were endorsed in December 2018 by the National Health Data and Informatics Committee.

Allied Health Admitted patient care NBPDS:
https://meteor.aihw.gov.au/content/index.phtml/itemId/705499

Allied health non-admitted patient emergency department NBPDS:
https://meteor.aihw.gov.au/content/index.phtml/itemId/705494

Allied health non-admitted NBPDS:
https://meteor.aihw.gov.au/content/index.phtml/itemId/705642

Allied health non-individual patient attributable and clinical support activity NBPDS:
https://meteor.aihw.gov.au/content/index.phtml/itemId/705789

Some jurisdictions including NSW and SA have developed Allied Health data sets including standardised allied health discipline-specific interventions.

15. ***Will the data submissions specified for the study support the analyses outlined for developing the ANACC?***

    Individual discipline input will be essential after the costing study to reassess the study outcomes and identify gaps in the short lists and apparent cost discrepancies.

16. ***Will the data elements outlined in the previous Chapter support investigating bundling of service events (e.g. into courses of treatment, episodes of non-admitted care, pre- and post-hospital admission etc.)?***

    Opportunities may exist to investigate this option for some common, high volume procedures i.e. knee or hip joint replacement surgery.

17. ***Will the data elements outlined in the previous Chapter support investigations of complexity of non-admitted service events? Are there other markers of complexity for non-admitted patients that should be built into the data collection?***

    See response to question 8

18. ***What are other uses of the ANACC in addition to ABF that need to be considered in its design? Does the proposed data collection suit these uses?***

    Possible uses of this data include health service benchmarking and health service research. The ability to link to existing data repositories that include clinical outcome data is worthy of exploration with appropriate data governance oversight.

19. ***Are there any other issues that should be considered in the conduct of this study?***

    No further comments at this time

Reference:

Health Policy Analysis 2019, Non-admitted care costing study: Public consultation paper 1 - data collection, Independent Hospital Pricing Authority, Sydney.