Non-admitted care costing study

Public consultation paper 1 – data collection

Queensland submission to the Independent Hospital Pricing Authority

Background

The Independent Hospital Pricing Authority (IHPA) is developing a new classification for non-admitted care – the Australian Non-Admitted Care Classification (ANACC) – to replace the current Tier 2 Non-Admitted Care Services Classification.

To support the development of the ANACC, IHPA has commissioned a consortium led by Health Policy Analysis to conduct a study of the costs of non-admitted care – the *Non-admitted care costing study*.

IHPA is seeking feedback from stakeholders on the first of a series of public consultation papers (*Public consultation paper 1 – data collection*) which was released on 30 April 2019, with all feedback due 5.00pm on 24 May 2019.

Directorate Position

The Department of Health consulted with all areas of Queensland Health (QH) which includes the Department of Health, 16 Hospital and Health Services (HHSs) and the Queensland Ambulance Service. This feedback is to be considered the view from QH. However, standalone HHSs may choose to provide specific feedback.

Feedback:

QH responses to the 19 Questions for Stakeholders as included in the consultation paper are included below.

1. What changes to the scope of the study, as described above, should be considered?

QH notes that the development of a new classification requiring data items which are not routinely collected will require significant information technology (IT) system changes. The cost of such changes and associated risk will be material and will compete against existing patient care priorities.

There would need to be demonstrable benefits at the hospital level ahead of introducing such a change.

Regarding the scope of the study, the scope is aligned to the National Minimum Data Set (NMDS) and National Best Endeavours Data Set (NBEDS) which includes public hospital services under contract. However, as additional data is required it would most likely not be reported from contracted service providers as any existing contract agreements themselves would not have the additional data items specified.

Some non-admitted care, or courses of treatment, may span across multiple facilities. For example, patient care may commence at a regional facility, then the patient be transferred to a tertiary facility. It is not clear how the costing study will capture such service events if not all facilities are participating in the study.

Some outpatient clinics can be influenced by seasonal changes in patient flow and presenting condition – particularly in rural areas where outreach happens quarterly. Given the relatively short timeframe of the study, services such as this may be missed.

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

QH requests further detail on the sampling strategy and key criteria ahead of nominating possible sites for inclusion in the study. For example, approximately how many outpatient clinics are expected to be included in the study, is there a minimum number of anticipated patients at each clinic, is there a minimum number of days the clinic is available (eg. some clinics may be provided once a month while others are provided three days a week).

Based on the selection criteria included in the consultation paper, it is likely that large facilities will be best placed in having the available resources to participate in the study. However, there is a risk that the results will be distorted if smaller and/or regional facilities are not included.

QH recommends that the sampling strategy incorporate a requirement for a representative spread of clinics across various services, facility sizes and locations.

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

The consultation paper notes that the site coordinator will be responsible tor staff training. It is not clear who will develop the training material. QH recommends that the core content of the training material be developed at a national level by the consortium/IHPA, with some local customisation as required and advised by the site coordinator. This would ensure there is consistency in approach and implementation and would ensure more consistent and comparable results.

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?*

It is likely that the costing study timeframe will overlap with clinical trainee rotations. QH recommends that such issues should be identified as early as possible by site coordinators to allow the Field Management Team (FMT) time to provide additional support where required. QH also recommends frequent (eg. fortnightly) updates with the FMT so that clinicians have the opportunity to highlight any concerns as the costing study progresses.

The consultation paper indicates that data will not be submitted to IHPA Secure Data Management System (SDMS) until the conclusion of the study. QH recommends the ability of the FMT to verify that data were being entered correctly at earlier stages to ensure data quality throughout the collection period.

The consultation paper notes that patient consent will not be required as the study does not pose any risks of harm or discomfort to patients. If a patient has not given consent for their data to be used for other purposes than to provide care, what are the implications for this study?

Regarding strategies to keep clinicians motivated to collect data accurately, QH makes the following recommendations:

1. The presentation of/access to summary level data for each clinic throughout the data collection period. This would allow for other clinicians not involved in the study to provide another perspective. It would also help highlight areas where there is a deficiency in data quality requiring further attention.
2. The data entry app be designed in such a way that data entry is not an overly time-consuming process. For example, pre-selected responses as opposed to free text (where possible) will be faster to complete as well as ensure consistency of information collected.
3. The consortium/IHPA provide clinicians with material explaining the intent of the study and draw the link between robust costing data and its impact on health service delivery, planning, and funding models.
4. Regular access to/workshops with FMT during the collection period to allow clinicians to work collaboratively and actively participate in the study.

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

Per the response in Question 4, QH recommends the app (both mobile and desktop) include minimal free text selections and preferably have menu-driven drop-down selections where appropriate.

There app should include the capacity to:

1. Indicate when the estimated duration or actual duration had not been recorded properly
2. Indicate when an adverse incident or other abnormal event has occurred which might impact on the service event costing
3. Exclude specific service events at clinician request.
4. Link service events across multiple providers for the same patient course of treatment.

Is it likely that the new WRITEitRIGHT app could be extended for use in the costing study?

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

QH recommends that the sampling strategy ensure that patients cannot be identified, and that IHPA's Aboriginal and Torres Strait Islander consultative mechanisms be used to discuss ethical considerations for data collection pertaining to Indigenous status. QH further recommends that the

clinician or coordinator should advise patients that additional data is being collected for a costing study with the ability for the patient to choose not to participate.

QH also requests that IHPA outline what will happen to the data once the study is complete. Will it be destroyed after a set period of time? Are there other intended uses of this data other than for the objectives of this study? If at a later time this data is considered for a different purpose, will participating organisations be consulted and their consent sought prior to use?

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

QH has not identified any unnecessary data elements.

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 this study?

QH recommends the following additions/amendments to the data elements in Table 1:

1. Data element: “Initial Service” – include an additional Value, “Significant Development”. For example, in Social Work a patient will build rapport with their clinician as time goes on and it is not uncommon for a patient to reveal significant information that could change the care plan or result in a longer than expected service even once trust has been established. Additionally, it is not always clear whether the service is initial or subsequent, particularly where a patient presents for multiple, complex reasons and subsequent appointments may not be a continuation of the first.
2. Data element: “Major reason for attendance” – currently one of the values of this data element is “Preventive care”. QH suggests that a new data element be included “Delivery of preventive care”. Preventive care is commonly provided in the course of delivering other services (rather than being a primary or secondary reason for attendance or a distinct intervention) and is therefore not mutually exclusive from the other reasons for attendance categories.

   The currently proposed format, where preventive care is combined with primary reasons for attendance, may under-estimate the delivery and costs of such services.

   The delivery of preventive health care in the course of care for other conditions should be collected as a separate variable with the specific type of care (such as smoking cessation, sexual health, obesity/nutrition, increased physical activity) identified. Preventive health indicators, such as smoking status or body mass index, are often not available in other secondary data sources or are not recorded consistently by clinicians.

   This level of detail is required to accurately capture the costs of unhealthy behaviours and delivery of outpatient care to the wider health system. Smoking, for example, has been associated with a higher likelihood of 30-day mortality and serious postoperative complications (Turan et al., 2011). A study of cardiovascular and oncologic surgeries reported that current smokers had higher odds of overall, pulmonary, wound, and septic/shock complications following most surgeries compared with non-smokers (Schmid et al., 2015). Findings such as these indicate that smoking cessation should be included in standard pre-surgery and post-surgery care delivery. Similarly, other conditions are exacerbated by characteristics such as body mass index or physical inactivity and delivery of appropriately costed preventive health care services in the course of other treatment services through

outpatient clinics could reduce overall health care costs and improve patient health and wellbeing.

About one-third of the overall disease burden can be attributed to the combined effect of modifiable risk factors. These same risk factors account for about 15 per cent of hospital admissions in Queensland and represent a significant expense across the health system.

References: Schmid M, Sood A, Campbell L, Kapoor V, Dalela D, Klett DE, et al. Impact of smoking on perioperative outcomes after major surgery. American journal of surgery. 2015;210(2):221-9.e6. Turan A, Mascha EJ, Roberman D, Turner PL, You J, Kurz A, et al. Smoking and perioperative outcomes. Anesthesiology. 2011;114(4):837-46.

3. Include Indigenous status as a new data element. Indigenous people experience greater prevalence of comorbidities. Culturally appropriate care underpins the outcomes of healthcare interactions with Aboriginal and Torres Strait Islander people, therefore these additional factors (cultural liaison, coordination etc.) must also be considered.
4. Include new data element that assists identifying courses of treatment that span across multiple facilities.
5. Data element: “Major reason for attendance” – suggest the inclusion of a value for “Maternity Care”. Ante-natal and Postnatal care are aligned to the Bundled Pricing for Maternity Care and are not captured. These cohorts do not easily sit in other current values.
6. Data element: “Clinical time duration: Minutes” – suggest the ability to enter as start/finish times or in minutes.

9. What clarifications or enhancements can be made to the definitions and/ or values of the proposed data elements in Table 1?

QH recommends the following clarifications to the data elements in Table 1:

1. Data element: “Initial service” should be renamed “Service type”. The current name suggests a value as opposed to a varied selection. The first value of this element is “Initial service for this patient” which strongly indicates a service type.

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?

QH does have concerns regarding quality of the short list and suggests that there is likely to be work required at the site level prior to the data collection phase. Some of the content for the short list, for example, 01-0057 Multiple sclerosis (MS) includes other demyelinating diseases and is aggregated to ICD-10-AM code G37.9. The Presenting condition term is misleading as it only notes Multiple sclerosis which should map to G35 Multiple sclerosis. The Presenting condition term should be consistent and note that other demyelinating diseases are included. Other Presenting condition terms include multiple concepts. I.e. Multiple sclerosis and other demyelinating diseases. Another example is 21-0078 Neurovascular injury to upper limb (excluding hand) is ‘mapped’ to aggregate International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM) code T14.4 Injury of nerve(s) of unspecified body region. The other conditions are assigned with their respective specified body location. It is unclear why this body region is not ‘mapped’ to T11.3 Injury of unspecified nerve of upper limb, level unspecified.

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?

QH recommends considering expanding the list of interventions to capture services provided by Indigenous health liaison officers and nurse navigators. The interventions, list procedures done to the patient but not necessarily all clinical care provided when the patient is not present. For example, interpretation of burns images via store and forward and response via email or telephone to assist in self-treatment in the home.

Secondary presenting conditions should also include chronic diseases and obesity.

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?

QH notes that several activities have been excluded under each intervention listed in Appendix B. For example, Clinical Measurement 30.08 does not include Exercise Stress Testing.

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?

Similar to the recommendations contained in Question 4, QH recommends that the process of data entry be made as simple as possible. With 13 primary data elements to enter, consistency of coding may be an issue. The following features of the app could be considered:

1. Where feasible have as many fields as possible pre-filled or set to a standard default.
2. Clinical time duration could be entered in minutes or start/finish times.
3. Availability of a manual collection sheet for clinicians to document easily and retrospective entry into app.
4. The ability of the data entry app to run in an offline mode if network access is not available – with the ability to update once back at base.

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

QH has not identified any additional sources of secondary data at this stage, but further sources may be identified depending on the selected sites.

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

Yes.

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.)?*

QH is of the view that the data collection timeframe will be too short to fully recognise bundled courses of treatment – particularly for patients with chronic disease. Data is needed over a longer period of time and should be whole of jurisdiction to allow for hub and spoke and inter-HHS service delivery models. For example, a patient with cardiovascular disease that received non-admitted care (pre and post-surgery) at a local hospital, then subsequently had to travel to another HHS for the surgery. The package of care for patients may also be delivered through telehealth with and without patients present and there will also be non-patient attending care planning. This study cannot fully represent the costs associated with these aspects of care.

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?*

Complex patients are unlikely to be adequately described or captured using the proposed data element “Secondary presenting conditions” (Table 1). Clinicians at individual clinics are unlikely to have complete medical records resulting in under-reporting of secondary conditions. Further, secondary conditions are often not assessed unless they directly impact on the primary reason for attendance. Relying on this mechanism of data collection will likely under-report patient characteristics such as complex life circumstances or co-occurrence of behaviours associated with poor health outcomes such as tobacco or alcohol misuse.

QH recommends the following additional complexity markers:

1. Clinical time duration may be a key determinant of complexity. Suggest a value to identify reasons for a long consultation including:
    1.1. Complex condition/ case history
    1.2. Care co-ordination
    1.3. Social reasons
    1.4. Language/ understanding
    1.5. Other
2. Consider a way to record if a patient is cognitively impaired, particularly for geriatric care.
3. Mechanism to include Socio-Economic Indexes for Areas (SEIFA) categorisation to allow robust analysis of population and illness trends, particularly chronic disease – noting that this may be possible from data already collected (suburb mapped to Statistical Area Level 2 (SA2)).

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?*

The ANACC is likely to be a valuable tool to assist future service planning; workforce planning; relationships/coordination with Primary Health Networks (PHNs) specifically around integrated care; public private partnerships; and, General Practitioner (GP) liaison/shared care to improve the patient journey and experience.

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

Some HHSs have expressed concern about the time impost on clinicians to enter the additional data and the associated impact on productivity this might have. Although the study will support the direct costs of a site coordinator, indirect costs such as productivity impacts are more difficult to quantify and therefore support financially.

As covered under earlier questions, it is not clear how the study will handle courses of treatment which extend over multiple facilities and HHSs, particularly in regional/remote settings. How such cases will be handled as a bundled course of treatment is of particular interest to QH.

Additional feedback

QH requests consideration by IHPA of services provided by Queensland Ambulance Services (QAS) as non-admitted patient services. By way of explanation, through the course of its operations, the QAS provides a number of services, which may meet the criteria of “non-admitted care”, as defined within the consultation paper. As an example, these aspects of QAS service delivery include, but are not limited to:

- care provided to patients across a range of circumstances, who following treatment by the QAS may not be transported onwards to a health facility;
- services provided by the QAS Local-area Assessment Referral Unit (LARU), in assessing, treating and considering alternative pathways for patients to a range of health care providers, according to the clinical need of the patient; and
- other alternate treatment and referral pathways utilised across the organisation (e.g. those specifically relating to mental health).

Please note however, that structurally the QAS operates within the Ministerial portfolio of the Minister for Health and Minister for Ambulance Services and forms a Division of the Department of Health, as opposed to forming part of any one specific HHS. To enable a more streamlined patient care pathway, service delivery integration between the QAS and each HHS is achieved at the local level through a range of interface points. The structural alignment between the QAS and its health system partners, when coupled with a clear organisational distinction between the QAS and the HHS (which includes differentiation across supporting systems, data, and operating processes) ensures that that the QAS remains responsive, agile, and well supported in a highly dynamic, highly complex, and unique 24 hour statewide operating environment.

In the context of the role of and services delivered by the QAS as the State’s ambulance service provider, this structural alignment of the organisation is a key difference which requires consideration in the context of the stated aims of the proposed study - specifically whether the QAS would satisfy the criteria as an entity to be considered ‘in-scope’.