Government of **Western Australia**
Department of **Health**
Purchasing and System Performance

Our Ref: F-AA-56757/3-101
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James

Dear Mr Downie

ANACC COSTING STUDY PUBLIC CONSULTATION 1 – WA SUBMISSION

Thank you for the opportunity to provide a submission to the public consultation paper for the Costing Study as part of the development of the Australian Non-Admitted Care Classification.

A consolidated reply to the consultation questions from Health Service Providers and the Department of Health is provided at Attachment 1.

Western Australia supports the development of a patient-centric classification system for non-admitted services and our Health Services are keen to participate in the costing study.

If there are any queries regarding the submission, please contact Giulia Clifford, Director, Budget Strategy on Giulia.Clifford@health.wa.gov.au.

Yours sincerely

Angela Kelly

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23 May 2019

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Australian Non-Admitted Care Classification Development Public Consultation Paper 1 – Data Collection

WA stakeholder comments in response to the consultation questions

1. **What changes to the scope of study, as described in the consultation paper, should be considered?**

   The scope is generally comprehensive and appropriate, but clarification is required whether community-based clinics include community health (e.g., child health).

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

   It would be useful to have a description of the skills and expertise required for the site coordinator. It is very important that all staff involved in the costing study including the clinical lead and costing staff are fully committed and understand their roles and responsibilities.

   The financial support from IHPA, which will be negotiated with individual sites, would be a critical consideration for participation and success of the costing study. This will ensure data entry/collection is undertaken accurately and in a timely manner.

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

   It would be beneficial to include a statement that describes how specialised a particular service is, compared to others in the same category. For example, an orthopaedic clinic in Site A may be providing highly specialised services compared to all other orthopaedic clinics across several sites. This will indicate how applicable the results from Site A would be to other orthopaedic clinics, specialty and/or site.

   Understanding if the selected site is significantly different will add value to the application of its Relative Value Units (RVUs) to other sites in the same category. RVUs generated from clinics providing general services will not adequately reflect the costs incurred by clinics providing specialised services.

   Some stakeholders requested that iPads with SIM cards be made available for ease of entering data. Scanners and bar codes for common activities would be useful to assist in capturing time taken for tasks such as referrals, letters to GP, reviewing results, etc.

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?**

   Data collection takes time and clinicians in Western Australia (WA) do not at this time collect/record data. Clinician support will be required to assist with data collection, other administrative tasks and interpretation of definitions to ensure they are applied consistently.

Suggested strategies to motivate clinicians include:

- Setting up of the event on a device so that it is readily available to collect/record data (i.e., no need to search for the appointment) will make it easier to use and more likely to be used.
- Daily monitoring of information by the site coordinator to ensure the collection is complete (i.e. allocated minutes vs total minutes of the clinic; validating missing data compared to entry in the Patient Administration System (PAS)) would mitigate the risk of incomplete data collection and non-compliance.
- Weekly review and acceptance/endorsement by the clinical lead would ensure data is collected accurately.
- A summary data set available at the end of each clinic time may help with motivation and accuracy. Clinicians are keen to have the data reflecting what they do in the clinics.
- Feedback on data collected from other similar clinic activity from other sites across Australia would interest clinicians. Access to this raw data summary would be useful as the study progresses.
- Regular communication from IHPA and their consultants on the progress of the study, key milestones and/or findings during the study period will also help in reminding clinicians that accurate data is essential as assumptions/decisions are being made based on their input.
- Provision of a pre-filled data template sheet that could be quickly completed by hand (if required) after a patient interaction and these sheets submitted to the data entry officer for data entry.

Point of entry implies timely data entry via the mobile or the web-based app. Data elements not routinely collected may need system configuration of the WA PAS.

There is a view of keeping data input requirements to the bare minimum to create RVUs. However, this may restrict the collection of potentially relevant information for future costing/pricing purposes.

For some clinics, the costing study would involve a change in practice; the clinic will see fewer patients than usual which could translate to increase cost/patient.

Time taken to input clinical data may result in need to reduce the volume of patients seen in a clinic which may pose clinical risk. Patients will end up waiting longer resulting in complaints. Some tasks undertaken for patients are done after the clinic has finished like checking results, and as such may not be entered as activity as the clinician is either not in the clinic environment with access to the iPad or desktop program or they simply forget.

Stakeholders understand the benefits of the costing study. However, it undoubtedly adds burden on a currently maximally stressed service, which will result in reduce clinical activity during the study period. A suggested solution is to 1) proportionally reduce staff clinical contact time during the study period (e.g., by 10%), and 2) to place a weighting of 1.1 (i.e. 110%) on the activity provided during the study period to account for a reduction in activity due to additional administrative duties required by 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?**

   Training, support and ease of use of the app are fundamental requirements. Staff should also be given the option of either using their own personal device or one that is supplied for the purpose of the study (iPad with SIM or phone). This will increase user acceptance to collect accurate data on time. Multiple staff need to be able to simultaneously enter data about the same patient within the app.

   Security protocols should be in place to ensure clinician and patient information is protected at all times whether these are stored on personal and/or work phones.

   A stakeholder commented that one entry point only via desktop is preferred as this will reduce training time and data entry-related errors. However data managers recognise that having both the option of the app via mobile device and desktop will increase the flexibility of the interface particularly outreach services.

   The app should include features that align with clinical practice in a non-admitted setting such as a function to search for a specific patient. For example, if the patient's surname is Smith, the app should be able to provide all first names of patients with a surname of Smith to minimise search time. Clinicians see many patients of the same surnames. Tailoring requirements to local practice would yield higher completion rate and accurate data.

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

   Page 9 of the Consultation Paper states that "*the app will include a facility for data encryption, so that no identifying information on patients or staff is submitted to IHPA, other than the identifiers currently submitted to IHPA through the National Hospital Cost Data Collection or Non-Admitted Patient National Best Endeavours Data Set*". WA does not at this time provide identifiers to any national submission. The Medicare number is provided separately to the Department of Human Services.

   Regarding data storage and sharing, will IHPA keep the costing study data or will the sites will own their own data? Will data be kept confidential from other sites/states?

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

   The data elements are sound, however IHPA may benefit from reviewing the jurisdictions' varied capacity to collect the proposed data elements from their respective PASs and within routine data collections as part of the costing study. The availability of data on current systems may need to inform RVUs for a classification to be practical and applicable outside the costing study.

   The data elements in Table 1 are not deemed unnecessary; however WA's PAS capture them differently. For example:
   - Reason for attendance is captured as Assessment, Research, Training and Ongoing Assessment.
   - Residential address is captured but not status.

- Interpreter used – the PAS captures that an interpreter was booked, but there is no update in the PAS as to whether they were used.

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?**

   Patient characteristic that may impact on cost that is not currently included is indigenous status.

   There should be consideration as to how complex social/welfare situations for patients at risks are recognised in the costing study. Homelessness has been accounted for, but issues relating to patients with culturally and linguistically diverse background, child at risk (involving the Department for Child Protection), and those presenting with reduced social supports that impacts on discharge planning and follow up treatments.

   Specifically for Genetics: Clinical service events with patients in clinical genetics should be categorised in the following way to assist with costing:
   - New patient, complex diagnostic assessment (congenital abnormalities, developmental delay or autism, assessment for dysmorphic features or developmental delay, assessment involving features that can manifest in 2 or more body systems, seeking an overarching diagnosis or 2 or more genetic disorders considered, genetic test result interpretation)
   - New patient, simple diagnostic assessment (single genetic disorder affecting a single body system considered)
   - Follow-up patient, complex (multiple issues discussed)
   - Follow-up patient, simple (single issue discussed)

   Furthermore, currently clinical service events in Genetics are weighted by type of health care provider (Clinical Geneticist or Genetic Counsellor). Such weighting discrepancies should not be applied, but rather complexity of clinical service events should be used to discriminate (see above).

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

   Comments regarding Table 1

   - *Did not attend flag*: Doesn't allow for case conferences where the patient is not present. Ideally there should be an extra permissible value for case conferences. Code 9 (Unknown) is not appropriate for MDCC since we know that the patient was not there.
   - *Initial service:* Some caution will be required as the clinician may rely on the patient to know if this is a first visit or not. WA prefers the use of first visit not new.
   - *Patient present: How w*ill this include home self-care activity?
   - *Service occasion end status:* This could include discharged back to referrer, the General Practitioner (GP). The practice in WA is, when the service is completed,

the patient is discharged and referred to their GP so essentially a combination of codes 1 and 4. But with only one code required, it's confusing which one to choose. It is assumed that code 1 includes GPs.

- *Clinical time duration (in minutes):* Is this asking for times for each of the 9 codes in type of clinical time or just one total time? This item may need to be treated as primary 'new' data element for the study. Clinical time would benefit from being reviewed both at an aggregate level and patient level. It is assumed that estimates are allowed (i.e., 7 min). Can clinicians report 7 minutes or will this be rounded up to 10 or down to 5 min?
- *Person residential status* may be confusing in WA since residential status refers to non-resident/refugee/etc.
- It is preferable if 'unknown' choices are excluded to encourage staff to allocate definite 'known' choices. Sometimes 'unknown' becomes a default and can make analysis meaningless.
- A review of the data items in Table 1 against what is available in the PAS needs consideration. If the items are not in the PAS and they become mandatory for classification purposes in the future, then enhancements to the PAS would be required, which will have strategic implications (ICT, financial, education/training).
- *Type of clinical time code 08* (teaching training and research), is a very confusing concept for those who are not involved with the TTR work. To most staff, treating the patient with students or trainees present meets both code 01 and code 08. Participating sites need to understand the difference between these two codes.

  Prioritising is a non-admitted cost (for the consultant and/or registrar) that should be captured as part of the costing study. Is this considered part of "other documentation" (code 04)? Some patients that are prioritised during the data collection for the costing study may not be seen during the study period except for urgent cases.
- *Major reason for attendance*
  - *New problem (code 2) vs chronic (code 3)* – a significant number of patients may be waiting more than 3 months for a new appointment for a new condition/problem. If it takes more than 3 months since the onset of symptoms to actual attendance, does this make it chronic?
  - On referral, patients are prioritised on the basis of their condition and are allocated a time limit when they should be seen (i.e., 30, 90 or 365 days). There are hospitals that have patients over their boundary limit. Based on the current definitions of the various codes, these patients could qualify as chronic, which is not accurate.
  - Specifically for Genetics: The values are not applicable to clinical genetics. Reason for attendance will often drive the complexity of the appointment and forms the basis for classifying types of Genetics appointments. A list of types of Genetics appointments are proposed under Question 8.

Comments regarding Table 2

- *Service delivery mode*: WA uses this field to identify both ends of telehealth and MDCC events.
- *Service delivery setting*: Only 2 of the 6 codes are part of the NBEDS. 1= On the hospital campus of the healthcare provider and 2=Off the hospital campus of the healthcare provider. Codes 2 to 6 below are not available.
  1 On the hospital campus of the healthcare provider
  2 Community health or day centre or other community facility
  3 General practice surgery or clinic
  4 Residential care facility
  5 Private residence
  6 Other hospital

Comments regarding Table 3

Some caution will be required to prevent over counting as there is common data in the Non-Admitted Patient NBEDS, Non-Admitted Patient local data and the Radiotherapy Waiting Times National Minimum Data Set. Also these are subsets of the total activity which WA calls "attended appointments".

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?

IHPA's advice would be appreciated if all the exclusions listed in the 'Exclusions' column are entered under their own 'Presenting Condition Term'.

Validation of items in Appendix A by relevant clinicians would be valuable i.e., cardiology list are reviewed by Cardiology Head of Department or the clinical lead.

Assuming that the app configuration enables grouping of most common presenting conditions, the list does not group conditions in a way that is meaningful to clinicians or aligns with clinicians or specialty clinic. The conditions are grouped based on the current Tier 2 classification codes and most clinicians are not familiar with these codes.

Feedback from clinicians was that Appendix A does not capture all conditions however; they acknowledged that there is difficulty in drawing a line on level of detail required. Clinicians suggested further clinical consultation with the site specialists chosen to participate in the study to confirm the range of conditions for that specialty. Oncology staff from a hospital suggested that more work is required before agreeing to conditions at Appendix A. For example:

- presenting conditions under Medical Oncology (pages 55-56) included eight (8) urology conditions not related to malignancy
- there are no items relating to General Surgery (Tier 2 - 20.07) or Vascular Surgery (Tier 2 – 20.24).

How would these and other conditions not on the list be captured?

Specifically for Genetics: Appendix A is not appropriate for clinical genetics. There are over 5,000 different genetic diagnosis listed in classifications of genetics and rare diseases (Orphanet Coding System). ICD-10AM has a specific code for less than 5% of rare diseases, and thus cannot be used to classify the type of appointment; 80% of rare diseases have a genetic association. Current (e.g. ICD-10AM) coding is a major and critical limitation of genetic and rare diseases coding in the Australian Health Care System. Pragmatically, within the time and funding limitations of this study, or with current databases and systems in place; this limitation cannot be addressed. Therefore, in the absence of the time and resources available to address this critical need, and for the purposes of the current study, it is better to classify based on complexity of appointment as proposed in Question 8. Furthermore, if codes listed in Appendix A is applied, complex interactions may well involve multiple presenting conditions (5 or more).

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?

Searching for secondary conditions will be time consuming. Will exclusions be visible in the app? For example, the primary presenting condition is 'injury to upper limb' which there is a Tier 2 code, but the secondary presenting condition may be listed under more than one Tier 2 codes. This will be a significant issue to search/find the correct condition. Clinicians may end up spending a considerable amount of time searching resulting in decreased data quality.

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?

IHPA's advice would be appreciated if all the exclusions listed in the 'Exclusions' column are entered under their own 'Intervention Term'.

The Intervention list in Appendix B appears to be limited. For example, there is only one intervention each for 'Carpal Tunnel' and 'Injections of Varicose Veins'. How would the other interventions be captured if they are not on the list?

Specifically for Genetics: In Appendix B under pathology there is no mention of Genetic testing. Genetic testing is frequently critical to delivering clinical genetic health care. Genetic tests require complex interpretation and the costs should be included, in addition to the costings for consultation itself, in the costing of a Genetics clinical service event when utilised.

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?

Consistent with comments to Question 4, clinician support is needed to ensure data collection proceeds according to plan (timely and accurately) in addition to the site coordinator. Support to apply definitions accurately and consistently with clinician

rather than direct clinician entry would be a big help. It is unlikely that clinicians will enter their non-face to face patient time accurately into the database due to significant time constraints.

IHPA needs to consider the potential bias of clinicians inputting the data themselves rather than deriving it centrally however it is acknowledge that responsibility for accurate data in the long term remains with clinicians. Data managers advised that the clinician should have the responsibility to collect the data as there are no coders for outpatient data collections.

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

Ancillary services data (diagnostic imaging, pathology, and pharmacy), referral systems, inpatient and emergency care systems are worth considering.

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

Yes, in consideration of comments provided to Questions 7-12 above.

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

Not entirely, a linkage with other data collections will probably be required using referral account number.

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?

A "priority" code similar to the Emergency Department triage system may also be needed. This will provide information regarding urgency of the patient to be seen.

Markers for consideration include complex social conditions, complexity score which is especially pertinent for tertiary sites where the percentage of complex patients is high.

The sample size in this study may not be able to statistically show a differential in cost drivers for complexity alone.

Clinicians believe that all pre and post activities for the outpatient events be taken into consideration. For example, all patient referrals would have been prioritised/triaged prior to the clinic appointment. This time should be included (even if it is an average to undertake the prioritisation/triage as agreed by the service), as well as time checking for results after the clinic has finished (days or weeks).

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?

Activity Based Management specifically for performance management indicators, research and service planning.

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

- A statement as to whether the data will be destroyed after the costing study is completed.
- It should be noted that some procedures or interventions are provided as admitted or non-admitted service such as endoscopy, sleep studies, chemotherapy and home birth. The variance in cost if the procedure is provided in either setting should be carefully considered.
- Consultation-liaison services in WA are currently recorded for mental health episodes only.
- Some concern that the nature of the study means that the data collected is only relevant to a specific clinician in that specific clinic at that time. Therefore it may not be able to be applied across an entire year or to other areas within the same specialty that are not included in the study with any degree of confidence.
- Diverse clinics and nature of patients they see could affect the power of study to capture the characteristic of the clinic and cost of service provision.
- In reviewing staff time and pay rate as cost drivers, the percentage of a clinician's time is dedicated to the specific outpatient clinic seeing patients vs total time. This will derive the appropriate cost allocation attributed to direct patient time. Unallocated time from the total time should be reviewed and accepted by the clinic lead and then most likely applied as an overhead (i.e. admin time, wastage time due to scheduling errors). HR data bases may be of use when considering clinical time, noting that the collection across jurisdictions may vary significantly.
- Specifically for Genetics:
  - While Genetic Services of WA (GSWA) is prepared to participate in a costing study to attempt to more accurately cost a clinical service event, clinical genetics is not ideally funded by an activity-based model (ABF). The service is by nature a multi-system; multi-disciplinary; whole of life span; individual, family and community based care. This model of care is not accommodated by ABF funding.
  - Clinical genetics service events should be based on outcomes achieved and measures of quality rather than quantity. Outcome quality measures could include diagnosis achieved, molecular explanation achieved, recurrence risk provided, targeted therapy able to be provided. Measures of quality could include patient satisfaction achieved, patient understanding achieved, etc.
  - Aboriginal and Torres Strait Islanders are underrepresented in genetic health care services, despite a demonstrated need. This is for complex reasons including distrust due to historical genetic research based initiatives and complex family and community structures. Clinical service delivery shows that special approaches that are specifically tailored to genetic health care delivery, and that are culturally safe and secure, are required to address this inequity of access and care provision. Genetic-specific funding considerations for Aboriginal and Torres Strait Islanders should be considered.