Austin Hospital
145 Studley Road
PO Box 5555 Heidelberg
Telephone 03 9496 5000
Facsimile 03 9458 4779
www.austin.org.au

31 October 2016

Mr Shane Solomon
Chair
Independent Hospital Pricing Authority
PO Box 483
DARLINGHURST NSW 1300

Dear Mr Solomon

Thank you for the opportunity to provide comment on the Independent Hospital Pricing Authority's Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-18.

Austin Health notes in principal support of the Independent Hospital Pricing Authority's proposals to introduce funding and policy payment reforms to support the improvement of safety and quality in healthcare.

We understand that one of the benefits of National Health Reform is that national activity based funding principles of costing and classifying / coding are improving nationally.

As a major tertiary provider, Austin Health is aware that good funding policy is underpinned by good quality data and data that is fit for purpose for funding model development. We also recognise that under these reforms additional data may be required for benchmarking purposes to enable clinical transparency for system improvement and change.

The proposed reforms are significant. They move away from paying for output, but for a defined record of quality of output. In developing the funding model, we encourage the Independent Hospital Pricing Authority to work with stakeholders to understand if the current National Cost Data Collection is fit for purpose for building funding models for safety and quality. As it stands currently this collection cannot decipher the day nor the type of resource consumed by patients which we believe are an essential ingredient to understanding costs to these cohorts of patients.

Further, we encourage the Independent Hospital Pricing Authority to recognise that some States will have coded these events in more detail than others and note that any funding model should be tailored to the level of maturity of each State and Territory and not penalise for it. The proposed system should also seek to reward providers of good quality care.

To ensure the success of these proposed changes it will be essential that health services' staff nationally provide input into the process to ensure that any reform can be implemented without bias at a health service level.

Yours sincerely

Bernadette MacDonald
Acting Chief Executive Officer
Austin Health

Encl.

Austin Health's response to the *Consultation paper on the pricing framework for Australian public hospital services 2017-18*

Austin Health Response to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2017-2018

4.4 What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient Classification

The IHPA may wish to consider in its development of Version 5 of the Australian National Subacute and Non-Acute Patient Classification:

- *Westmead Post Traumatic Amnesia Scale for Brain Dysfunction Impairments*
- *International Standard of Classification of Spinal Cord Injuries to classify spinal Cord Injuries. The standard is endorsed by ASIA – American Spinal Injuries Association and is known as ASIA score.*

6.1 Should IHPA consider any further technical improvements to the pricing model used to determine the NEP for 2017-2018

As we understand States and Territories are working through their own collections to improve areas of costing and classification to assist with further refining the NEP. It should be noted that:

- *In Victorian DHHS 2017-2018 VAED Proposal Phases of care data item was not included and until this data item is collected the impact of this cannot be modelled*

6.3 Should IHPA further restrict year on year changes to price weights

- *We agree with current 20%, however this should be reviewed where there is a significant impact to health services or Diagnosis Related Group change where there are high cost episodes.*

What are the priority areas for IHPA to consider when evaluating adjustments to NEP17

- *Areas of significant service change given changes in demographics and patient cohorts. For example, services such as Interpreters should be reviewed for cost impact. These services are required for informal consent and represent a fixed cost of care that are not recognized. Health Services have available to them (outside of the NHCDC specifications) evidence to support both the volume, type and frequency of patient utilization of these services.*

What patient-based factors would provide the basis for these other adjustments

- *In some instances, data collections cannot capture the necessary information describing the relevant patient based factors to enable adjustment.*

    - *For example, in the case of interpreter services, a number of Jurisdictional data collections do not capture the frequency and type of interpreter booked or used. Using country of birth may not be a sufficient proxy to model an adjustment.*
- *A separate supportive collection demonstrating which patients have utilized these services may be a better option to model adjustments and a copayment could be built based on this cohort who have accessed these services.*

7.3 Should IHPA phase out the private patient correction factor in 2017-2018 if it is feasible to do so

- *The capture of private patient medical costs in public health services can be difficult to decipher. IHPA should maintain their current approach until Version 4.0 of the Australian Hospital Patient Costing Standards have been implemented before reviewing their approach.*
- *IHPA should also consider further work that reviews the private patient costing methodology approach for all hospitals in the NHCDC before making any significant changes to their current approach.*

11. Pricing and Funding for Safety and Quality

The National Hospital Cost Data Collection

We encourage the Independent Hospital Pricing Authority to work with stakeholders to understand if the current National Hospital Cost Data Collection is fit for purpose for building funding models for safety and quality.

Currently the National Hospital Cost Data Collection collects data by activity by cost areas (pathology) and cost types (salaries and wages, goods and services, medical supplies.) These costs are then aggregated at patient level. As it stands currently this collection cannot decipher the day nor the type of resource consumed by patients, which we believe are an essential ingredient to understanding costs and funding model adjustment transparency.

Taken further, the format of the National Hospital Cost Data Collection does not enable you to decipher if high patient costs are a consequence of their appropriate treatment regime, inefficient practice (say the ordering of multiple pathology tests) or due to the need to treat the adverse event.

The Independent Hospital Pricing Authority should consider if intermediate products can be used to inform funding models for safety and quality. Intermediate products generally describe the type of resource consumed and Australian patient costing systems highlight these at the patient level by date of service or a daily basis.

The Strategic Review of the National Hospital Cost Data Collection made note that the "The NHCDC advisory committee should evaluate the appropriateness of using intermediate product costs in identifying clinical variation, and provide advice to the Pricing Authority through the IHPA CEO."

To further inform the Independent Hospital Pricing Authority to whether the current specification of the National Cost Data Collection is fit for purpose to inform a safety and quality funding model they should reference the outcomes of the Culturally and Linguistically Diverse Costing Study whose approach was based on data in the NHCDC format vs those in The Radiotherapy Costing Study whose approach was based on the use of intermediate products derived from costing systems within a

health service. In the latter, the study was able to identify the type and frequency of use of resource to inform resource/service utilisation across a range of patient cohorts to inform funding model development. This could not be achieved in the former.

We believe there is merit in examining the use of intermediate products to inform the proposed safety and quality funding reform options, but also recognise that work would be required to ensure that this form of data can be universally derived and adopted nationally.

11.4.1 Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, and all care settings

- *Yes, there is general support for investigating and modelling safety and quality in health care further. However, we also ask the IHAP to consider the following:*
    - *At this point in time, the data may be too immature, or not fit for purpose to enable transparency of the impact of adverse events in a funding model*
    - *The acute admitted setting would be the better place to trial the proposed reforms before looking to expand in other settings*
    - *Any payment model should be shadowed in the first instance to test its level of maturity*
    - *Investment will be required to increase workforce in areas of coding and other data areas that inform the funding model*
    - *Reporting should of these events should where relevant be expanded across all settings*
    - *The reporting requirements should also extend to private hospitals*

11.4.4 What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care

- *Prior to assessing any risk adjustment factors, more information will be required to understand how will IHPA capture "that hospitals have taken the necessary actions to manage their risks and adverse events in high risk patients?" This is documented data in the medical record and not captured in any current data collection.*
- *Further, where it is noted in the medical record, who will determine if the action taken was appropriate or not?*
    - *How and who will be tasked with investigating and determining this?*
- *Currently the IHPA funding model makes no copayment provision for health services with statewide services such as spinal services where the most complex patients are grouped to the same DRGS as those without complexity. Where complex patients can develop an adverse event given their complexity and this is known to the health service - how will the proposed model treat these?*
- *A risk adjustment funding model for safety and quality should have a redistribution pool within it. It needs to demonstrate that it is not driven by reducing the total funding layer for health services, but to promote and reward good quality providers.*
- *The model needs to also ensure:*
    - *There are no perverse incentives for health services to not code the adverse event*

- *Take into consideration the type, scale and the patient population the health service serves to ensure risks are fully captured and considered before applying any proposed penalty*

11.4.5 Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding for safety and quality? Are there other criteria that should be considered?

- *We have in principal agreement for the assessment criteria. However, we are unsure from the current data collected how IHPA can implement these criteria.*
- *For example we are concerned about the transparency criteria:*
  - *Coding – There is a real threat that adverse events may not be fully coded.*
  - *Costing – It could be argued that the NHCDC is not fit for purpose for modeling the impact of safety and quality issues in a funding model as it does not demonstrate resource consumption on a daily basis. Health services have no means to demonstrate to their clinicians the full impact of an adverse event in the funding model.*
- *There may be an incentive for health services to be patient selective so as not to risk decreased payment for adverse events. This model may also create a change to patient care where a group of patients are transferred out or discharged from a health service to minimize their risk and payment exposure.*
- *Conversely how will the model reward health services who may accept a higher volume of risky patients or transfers in from other hospitals?*
- *How will the model reward hospitals with lower adverse events?*
- *The model will need to also ensure health services are provided with funding certainty to ensure it is able to plan for its service delivery.*

11.5.4 Do you support the proposal to not fund episodes that include a sentinel event? If not what are the alternatives and if not how could they be applied consistently?

- *We have in principal agreement for the assessment criteria. However, we are unsure how IHPA will link the current collection by jurisdictions to the coded the current electronic data collection. For example, procedures for wrong body is not currently coded.*
- *How will the funding model treat patients who were admitted to another hospital (procedure not done at this hospital) with one of the defined sentinel events?*

Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?

- *We have in principal agreement for this flag. However, there will be a time lag and it will require an investigation to determine if it is a sentinel event.*
- *Health services will need to work with their Jurisdiction to collect this information as they are the system managers and manage their own jurisdictional data collections. This was not included in the proposals for Victoria for 2017/18.*

Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?

- *There is in principal agreement. However, please note the concerns above. For any agreement, further detailed information is required on the funding model, its assumptions, how data from current sources have been used and impact.*
- *Will no funding be provided to the episode where the sentinel event has been identified, but there may be an event at a prior episode at the same or other health service.*
    - *How will IHPA link the data between episodes.*
- *We would also query the Commonwealth's funding approach to these events. Where the Commonwealth does not pay for their share of the episode with the Sentinel event, will it distribute this funding to other health services? Will there be a pool of funds for redistribution.*
- *Will health services with no sentinel events be rewarded for their patient care?*

11.6.5 What are the advantages and disadvantages of Option1 which reduces funding for some acute admitted episodes with a HAC?

- *In principal agreement. The model appears to be simpler and transparent but requires an adjustment to reward good quality providers*
- *Please note the concerns above.*

Do you agree with IHPA's assessment of this option?

- *In principal agreement. However, the cost data should also be examined to ensure that costs reflect the complexity of care less the hospital acquired condition. Please see our comments on the National Hospital Cost Data Collection which are relevant here.*

11.6.6 What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates?

- *We do not provide in principal agreement with this option as we believe it does not provide health services with certainty of their funding*

Do you agree with IHPA's assessment of this option?

- *We do not provide in principal agreement*

What are the advantages and disadvantages of the approach to risk adjustment?

- *Uncertainty of funding is a disadvantage*

11.6.7 What are the advantages and disadvantages of Option 3 that adjusts funding to hospitals on the basis of differences in their HAC rates?

- *This option appears to rewarding good patient care / experience, but it also assumes that all hospital acquired conditions are avoidable*
- *This option requires further work to understand how health services are also protected from unavoidable risks*
- *Also the funding model appears not to redistribute back into the funding pool for good quality of care. This approach appears to remove funding from the system.*

Do you agree with IHPA's assessment of this option?

- *We do not provide in principal agreement*

Are there any other pricing or funding options that IHPA should consider in relation to HACs?

- *Not at this stage*

11.6.8 How should IHPA treat hospitals with poor quality COF reporting?

- *More detail is required to enable assessment*
- *COF accuracy would only be known from an audit. It could not be established by current data collections submitted to the Department of Health and Human Services Victoria.*
- *Would the requirement be to audit all episodes to validate this – Is this practically possible?*
- *If a rate is applied how will the rate be determined and what cohort would be used?*
- *Again there is uncertainty of funding as this would be retrospective*

11.7.3 What approach is supported for setting timeframes within which avoidable readmissions are measured?

- *Uncertain at this time.*

Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes?

- *We are not aware of any guideline or recommendation*

11.7.4 Is there support for pricing and funding models to be bases on avoidable hospital readmissions within the same LHN?

- *Based on our interpretation of the proposal we believe pricing and funding models for avoidable hospital readmissions must be across the board and not specific just to LHN*

11.7.7 When should a pricing and funding approach for avoidable readmissions be implemented?

- *Once the following has been addressed*
    - *Improved data collection and more recent data*
    - *Factors such as demographics, peer grouping and continuum of care assessments (such as linkages to primary care providers) are analyzed and noted for risk*
    - *Consultation and agreement on model*
    - *Impact analysis and shadow funding*

11.8.2 What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?

- *Broad industry consultation*
- *Review of data and its fit for purpose*
- *Development and refinement of definitions, collections and standards*
- *Assessment of systems and their reliability to capture the required information nationally*
- *Assessment of workforce capability and investment*
- *Impact analysis*
- *Adequate lead time*
- *Funding certainty*
- *Shadow funding models*

Do you agree that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models?

- *In principal agreement, subject to further information*