Feedback

Consultation paper on the Pricing Framework for Australian Public Hospital Services 2017-18

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3	**Scope of Public Hospital Services** **(Box 2: Scope of Public Hospital Services and General List of Eligible Services)** **Home ventilation** Queensland supports that home ventilation programs be reviewed once the full scope of the National Disability Insurance Scheme is known. Although low in volume the cost is higher than funding. Queensland further requests that as part of the review that the services scope and costs are considered based on age as well as other patient factors.
4 **4.4 & 4.5**	**Classifications used by IHPA to Describe Public Hospital Services** **Australian National Subacute and Non-Acute Patient Classification and Tier 2 Non-Admitted Services Classification** *What additional areas should IHPA consider in developing version 5 of the Australian National Subacute and Non-Acute Patient classification? (Section 4.4)* **MNT HHS:** It is welcomed that IHPA is improving the categorisation of Geriatric Evaluation and Management (GEM) patients and refining the current version (2016-17) to include cognitive screening (the Standardised Mini-Mental State Examination (sMMSE), and subsequently linking funding to the severity of cognitive impairment in addition to functional impairment. Currently, the GEM categories consider the Functional Independence Measure (FIM) for functional impairment and broadly consider delirium or dementia in the price weight however based on the information received, it appears that with AN-SNAP Version 5 pricing, consideration will be given to the severity of cognitive impairment based on the sMMSE. Clinical staff have advised that the FIM is not considered a good cognitive screening test and it should not be used for this purpose. As the FIM will still need to be performed, this means that the sMMSE will need to be done in addition to the FIM on all GEM patients. However preliminary advice indicates that it is not anticipated that this will be an additional burden as the sMMSE is already utilised for cognitive screening. Overall Metro North HHS supports the SNAP developments proposed for 2017-18 and it is acknowledged that IHPA has taken into consideration feedback provided regarding the limitations of the GEM SNAP classes in comparison to rehabilitation. In regard to section 4.5 Tier 2 non-Admitted Services Classification, Metro North HHS welcomes the

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	introduction of additional data items in the non-admitted data sets to capture non-admitted Multidisciplinary Case Conferences (MDCCs) where the patient is not present. Initial feedback suggests that there are opportunities across the HHS to contribute towards this new reporting category. Queensland notes that the area that could be addressed is the overlap between the ambulatory SNAP classes and the Tier 2 non-admitted clinics. The Tier 2 clinics are currently priced and used for funding, and IHPA is progressing the Australian Non-Admitted Care Classification (ANACC). There would not appear to be any purpose in having ambulatory SNAP classes and they should be removed from the classification. With respect to the planned AN-SNAP work to be undertaken, further refinement should be data driven by a critical mass of robust data. If the numbers of costed patients are inadequate, further refinement should not progress. The state implemented a significant enhancement in the patient administration system (effective from 1 July 2016) to enable the capture of data to classify sub and non-acute episodes into AN-SNAP v4. The enhancement also included the capacity to report on the Standardised Mini Mental Examination for Geriatric Evaluation and Management patients should it be incorporated into future versions of AN-SNAP The paper refers to development of AN-SNAP v5 in 2017-18. As jurisdictions are still in the early phases (first 1-2 years) of implementation of AN-SNAP v4, further changes to the classification that might require costly changes to patient administration systems would not be ideal. The paper also refers to the review of the non-admitted branches. A recent AIHW paper developed on behalf of the National Health Information Standards and Statistic Committee (NHISSC), to consider options to improve the comparability of national admitted patient data identified significant variations across states and territories in same-day admission practices for sub-acute care, particularly rehabilitation. In some jurisdictions services are provided as admitted care (usually as part of a same-day admission) and as non-admitted care in others. For example, in 2013-14, almost 50% of public hospital separations in Qld for rehabilitation occurred on the same day. Only South Australia reported a higher proportion (62%), with the lowest reported by Victoria (0.3). In the absence of a national admissions policy/framework, consistency of admission for subacute care (particularly for same day admissions) may be driven by the development and implementation of a funding model for the non-admitted branch of the AN-SNAP classification.
6	**The National Efficient Price (NEP) for activity based funded public hospital services**
6.1	**Technical Improvements** *Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2017-18?* **MNT HHS:** Metro North HHS is continually assessing service delivery to ensure safe practices and patient centric models of care. There are currently several departments considering on-line service provision including maternity antenatal education classes. If these educational sessions are transitioned on-line, the service would no longer be reportable under current classification rules. Metro North HHS recommends that IHPA recognise technological advancements to ensure organisations do not continue

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	to operate business as usual models of care and instead critically assess alternate service delivery opportunities to ensure best practice care provision. Specifically in relation to on-line educational services, Metro North HHS requests that IHPA consider a classification system / funding model similar to telehealth. **SUN HHS:** In regards to further technical improvements to the pricing model used to determine the NEP for 2017-18, IHPA should consider consistent treatment of long stay patients across all jurisdictions. Queensland notes that in section 6.1.2 Pricing Mental Health Services, IHPA indicates looking for a suitable proxy of phase of care. If there is an alternate proxy from existing data why would a new data element of phase of care be required – particularly given that only administrative data is being used and would require a change in the data collection? Asset maintenance: As part of the review of the Pricing framework for Australian Public Hospital Services 2017-2018 can the price for asset maintenance and facility management be articulated from the NHCDC data, so that the framework can specifically address this factor and lead to improved identification of cost variance nationally and by facility type. Non-admitted pricing has the lowest explanatory power of any of the classifications. The Queensland model differentiates between new and review patients (where it can be justified). It is recommended that IHPA consider these factors in the pricing framework. It is recommended that IHPA explore differential pricing for adult and paediatric patients with regard to the Tier 2 non-admitted procedure clinic 10.19 Ventilation – Home Delivered.
6.2	**Adjustments to the NEP** Inpatient pricing methodology is considered robust with the exception of NICU bundling. Analysis undertaken by IHPA supports the unbundling of NICU payments in the same way as other ICU payments.
6.2.2	**Patient Remoteness Area Adjustment** Queensland supports the use of SA2 (rather than postcode) as an initial indicator of patient remoteness. This will provide improve the accuracy of determining the remoteness measure.
6.3	**Stability of the National Pricing Model** *Should IHPA further restrict year-on-year changes in price weights?* Significant technological advances might increase the price weight of a DRG by more than 20% in a year, e.g. the introduction of endovascular clot retrieval for stroke; and in these cases, it would be appropriate to reflect this change in the price weights. **Queensland** notes that the main area of instability within the NEP is with respect to non-admitted pricing, which has had major swings from one year to the next. This has been predominantly driven by the gradual compliance with data submission to the NHCDC for non-admitted activity. It is noted that in the recent analysis of the non-admitted data by IHPA highlighted the significant cost variance for Queensland in the delivery of services; it is recommended that IHPA identify at the cost bucket level the

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	variation in cost when determining the pricing for non-admitted services, and are explicit in the adjustments and impacts when applying any stability of the National Pricing Model. **MNT HHS:** Metro North HHS supports the proposal that price weights remain fixed over multiple years unless a significant issue has been identified in the base-line calculations or when the cost of services has changed significantly. The current process where price weights change each financial year creates challenges for cross financial year reporting and compounds the issue of classification changes when analysing granular data elements including Diagnosis Related Groups (DRGs); there are also delays with reporting whilst new models are incorporated into reporting systems. Setting the price weights for an extended period would mitigate the issues outlined above and ensure a sustainable and robust reporting platform. **SUN HHS:** No, the prices need to be reflective of current practice not based on historical data that does not reflect current practice. *What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available. (Section 6.3)* Patient based factors/data such as chronic conditions could be utilised to inform the price weights and associated adjustments. The Admitted Patient Data Collection now has 12 months of data (supplementary codes for chronic conditions (U78.- to U88.-)) that could be used. Analysis of the 2015-16 data highlights the number of chronic conditions that are prevalent in the population. For 2015-16, 730,657 episodes of care had 2 or more supplementary codes for chronic conditions assigned. *What are the priority areas for IHPA to consider when evaluating adjustments to NEP17?* **MNT HHS:** As noted above under “6.1 Technical Improvements”, Metro North HHS recommends the IHPA identify priority areas for evaluation based on emerging technologies. Technological developments frequently demonstrate improvements in patients outcomes, however the funding model does not recognise service delivery cost increases for a number of years. Examples of evolving technology include on-line service delivery, expanding telehealth and alternate models of care that avoid hospitalisation or presentation. General comments - Metro North HHS requests IHPA consider interventional procedure adjustments be applied to all patient episodes (not just acute). The application of these adjustments to SNAP episodes acknowledges the additional resources required to perform the acute interventions. Metro North HHS also recommends IHPA consider establishing an adjustment for admitted hyperbaric treatment. In 2015/16 499 patients received admitted hyperbaric treatment in Metro North HHS facilities across a range of 41 different DRGs. For DRGs where there were more than 100 separations with hyperbaric treatment, the average cost of these patients was 63% higher than patients coded with the same DRGs who did not undergo hyperbaric treatment. Due to the limited number of hyperbaric chambers operating across Australia and the lack of specificity associated with the DRGs assigned to these patients, the additional cost of this specialised service is not adequately funded through the current IHPA funding models.

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7	**Setting the National Efficient Price for private patients in public hospitals**
7.3	**Pricing Private Patients** *Should IHPA phase out the private patient correction factor in 2018-19 if it feasible to do so?* **MNT HHS:** Metro North HHS supports the proposal that the private patient correction factor be phased out in 2018-19 if it is feasible to do so. The private patient correction factor assumes all private patient costs are missing from the National Hospital Cost Data Collection (NHCDC) and this is not correct for Metro North facilities. **SUN HHS:** Yes as it may be unfairly applied to some jurisdictions. Queensland supports the removal of the private patient correction factor. With changes to the 2014–15 costing standards to split costs by private and public patients then it would seem appropriate to move towards the decommissioning of this correction factor as an incentive to improve costing information. It would appear relevant to apply the private patient cost adjustment on a jurisdiction by jurisdiction basis.
9	**Bundled Price for Maternity Services** *Do you support IHPA's intention to introduce a bundled price for maternity care in future years?* **MNT HHS:** Metro North HHS supports the concept of a bundled price for maternity care however concerns have been raised in relation to the inclusion of the birth episode. Non-complicated vaginal births or uncomplicated caesareans could be considered, however due to the wide variation in complexity of birth episodes, it may well be prudent for the bundled price to initially only consider antenatal and postnatal care. In regards to what stages of maternity care and patient groups should be included in the bundled price - as noted above, Metro North HHS recommends that initially antenatal and postnatal care only be included in the bundled price. If any other stages of care are bundled, exclusions for admitted patients should be applied based on a list of complex medical and pregnancy related conditions and complications. Metro North HHS also recommends that IHPA evaluate expanding the outpatient classification system to provide accurate identification of complexities which influence resource utilisation. In regards to whether IHPA should include postnatal care provided to the newborn in the bundled price? - Metro North HHS supports the concept that newborns be included with the bundled price, however this should be limited to unqualified babies only. This cohort of patients would be more likely to consume similar volumes of resources once complex conditions have been excluded. In regards to other issues IHPA should consider in developing the bundled price? - As outlined above, Metro North HHS supports the concept of a bundled price for antenatal / postnatal

care and possibly non-complex births in future iterations of the funding model. Clinical staff have provided feedback that bundling based on mode of delivery alone is not supported as this does not accurately reflect complexity of care and conditions including prolonged admission for ruptured membranes, pre-eclampsia and diabetes that do not necessarily influence the mode of delivery. For example, a vaginal birth can include complex medical treatment and the level of care provided may not be adequate within a bundled arrangement. As a tertiary referral centre, Metro North HHS is particularly concerned about this as the impact will be greater for tertiary facilities.

The consultation paper notes that private patients and public patients under formal "shared care" arrangements should be excluded from bundled pricing. Shared care patients can account for a significant proportion of maternity patients within some facilities. It should be noted that as the scope of exclusions increase, this will devalue the need and effect of bundling in the first instance.

Clinical staff have also raised concerns in relation to utilising age and parity within bundling. These metrics will add further complexities and will offer limited value for inclusion in a bundled payment. Parity is not routinely collected as part of ICD-10-AM clinical coding. Currently ICD codes only exist for elderly primipara, very young primipara, elderly multiparity and grand multiparity.

SUN HHS: Can it be assumed that all ante-natal and post-natal care be bundled into a consistent single price?

In regards to what stages of maternity care and patient groups should be included in the bundled price

- non-admitted components only as inpatient care can vary widely depending on mode of delivery, complications etc.

In regards to whether IHPA should include postnatal care provided to the newborn in the bundled price?

- No comment

In regards to other issues IHPA should consider in developing the bundled price?

- How the data is going to be captured and counted across all jurisdictions.

Queensland has identified further considerations for bundling for this particular topic:

- The cohort is not homogenous. It can be made to appear homogenous by aggressive trimming of outliers, but including complex as well as non-complex patients ignores the higher risk factors, particularly those associated with caesarean deliveries and low birth weight neonates.
- The model can only be applied retrospectively with 100% linkage to non-admitted events. Queensland does not have 100% coverage of non-admitted unit record data and the administrative impost of data linkage is substantial.
- There should be further exploration of the opportunities around bundled pricing however maternity care is not an appropriate early topic. This is due to maternity pathways crossing primary/secondary care, public/private sectors, and financial years. This means that assessing the actual /typical volume of service utilisation is unreliable. Also, IHPA identifies its aim in Section 11 of "ensuring funding models are designed to support safety and quality"; therefore an approach which reimburses based on 'average' service cost/utilisation does not align with this aim. Rather, the bundle should reflect

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	good clinical practice – as per endorsed national guidelines – actual average of 8 antenatal visits does not 'largely align' with national antenatal care guideline recommendations of 10 antenatal visits for first time mothers- it would act as a deterrent to providing care in line with the nationally agreed guidelines. • In regards to whether IHPA should include postnatal care provided to the newborn in the bundled price - Only if the newborn is "uncomplicated' and unqualified. • Issues such as rural and remote service availability and provision needs to be considered. Many non-metro facilities do not have the same access to specialised obstetric clinicians which may impact the antenatal and postnatal care available. Also, patients in rural and remote locations often have to travel greater distances to access services. There would also need to be consideration as to how to manage maternity patients that might have to deliver at facilities that don't have obstetric/maternity units. I.e. Rural patient is booked to deliver at Facility A which has a maternity unit, but due to the urgency of the delivery has to deliver at Facility B which does not have maternity services. • There seems to be an assumption that the antenatal and postnatal care are provided by the facility where the patient was admitted to deliver. How will bundling be managed where the patient receives antenatal care at one facility but plans to deliver at another due to facility capability, services, distance? • The bundling of maternal care could also be seen to discourage shared care – care for a patient shared between different providers. • The reporting and data quality of the data element 'Episode of admitted patient care—admission urgency status, code N' (METeOR identifier: 269986) also needs to be considered in regards to bundling as this may assist in identifying "complicated maternity patients". Understanding the differences in jurisdictional reporting of this data element will be essential.
10	**Setting the National Efficient Cost** IHPA uses the National Public Hospital Establishment database to develop the NEC. There have been several issues identified with the transformation of 2014-15 NPHED for calculating each Reporting Facility cost base (IHPA In-scope Cost): • Raw Expenditure excluded "Other Admitted Care" from "Admitted Total" which Queensland consider should be included in accordance with the AIHW Meteor definition of services, in respect of Queensland services that was valued at $18M in 2014/15. • 'Maintenance' patients should not be out of scope for NEC when they are in scope for ABF pricing and funding Refer to AIHW definitions on Total Expenditure by Product Streams, 'Maintenance' are to be categorised under "Other Admitted Care" which should be included in "Admitted Total" and "IHPA Raw Expenditure" accordingly. • The deflation rate (NWAU to GWAU ratio) is applied by IHPA to remove Private Patients funded by other sources to Admitted, Non-Admitted and Emergency patients. We recommend only "Admitted" to be applied with deflation rate as the proportion of patient type has no impact to the cost of services provided for Non-Admitted and Emergency patients, in these hospitals. • Costs associated with the extensive travel undertaken to transfer/transport patients from rural and remote locations is recommended to be identified separately to other hospital/facility running costs. •

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	South West HHS: In terms of the NEC for Block Funded Hospitals, aggregating the data for all Health Facilities that are deemed to be too small to be eligible for ABF can disadvantage Block Funded Hospitals that are in a Remote region. There is a large proportion of Block Funded Hospitals that are located in Coastal and Metropolitan areas whereby the cost of clinical service provision is not as high as Block Funded Hospitals that are in remote areas. There are many Hospital and Health Services and Health Service Districts that have all of their Facilities funded 100% by Block Funding as they are in a Rural and Remote setting. These HHS's should have an individual pool for cost allocation rather than being included in a data pool which includes Block Funded Facilities in Coastal and metro based HHSs.
11.4	**Overview of Scope and Approaches to Pricing and Funding** *Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?* **MNT HHS:** Metro North HHS supports pricing and funding for safety and quality, however concerns have been raised in relation to capturing the necessary information to support these models across all patient types. Coded inpatient data will provide a significant volume of information to support this initiative however this is not available for all patient types. **SUN HHS:** QLD already has some components of these in their Activity Funding model. Some research needs to be conducted across the jurisdictions to see what is currently in place and work with the experience already gained in this area. Safety and quality if paramount in all areas of care. In general this is supported, however clear definitions and ensuring that the issue / definition is relevant for all areas is critical. Alignment to other national definitions and measures should be utilised wherever appropriate. The scope being all public hospitals, services, patients and care settings should be considered. The paper identifies that pricing approaches to safety and quality cannot be implemented on block funded hospitals as the National Efficient Price (NEP) does not apply to these hospitals. If a pricing approach is taken for a component of the Safety and Quality framework, an approach relevant to the block funded hospitals should be considered. Block funded hospitals are generally the smaller, more regional, rural and remote hospitals which are those hospitals that are generally more at risk of safety and quality issues given they are more susceptible to issues that contribute to poorer safety or quality i.e. availability, experience and skill-mix of workforce. Exclusions or trim-points also need to be considered carefully. Often small hospitals are excluded for monitoring purposes because of smaller numerators or denominators. If smaller numerators or denominators are an issue for elements e.g. the Hospital Acquired Complications (HACs), a variation on the methodology may be applied. In addition to the reasons above for including small hospitals, the appropriate approach for inclusion of small hospitals will ensure the quality of care in every hospital regardless of size is monitored, providing the message to the public and clinicians is that the quality of care in every hospital regardless of size equally matters! General comments: • *Behavioural responses* — insufficient discussion of possible unwanted provider behavioural responses to pricing/funding changes. • There is commonly a trade-off between incentives and risk-sharing. If funders (risk-neutral) shift too much risk to providers (risk-averse), providers may respond by lowering quality or ceasing

treatment / diverting higher risk patients / decreasing the accuracy of coding.

  - As clinicians also generate the data they are assessed on, coding behavioural responses need to be considered seriously.
  - Not clear the options have considered how to constrain bad behavioural responses to these funding changes? Evaluation of the changes to ensure this doesn't occur is recommended.

- *Evaluation* — for the HAC proposals there may be merit in running a cluster randomised trial to see if the funding changes actually do improve safety outcomes (and reduce costs) or instead increase unwanted behavioural responses (undermining original policy objectives)?
  - The funding changes seem modest in scale ($5m for Sentinel events through $486m for Option 3 HACs).
    - This could raise questions of whether policy will be effective in increasing safety.
    - Though modest scale might also suggest rigorous evaluation may be unnecessary.
- *Implementation difficulties* — almost all the options are assessed as having 'ease of implementation' – this assessment is arguably heroic in a number of cases.
- *Sticks over carrots* — all the options reduce funding (admitting Option 3 HAC proposes some positive redistribution). Notwithstanding federal fiscal imperatives, it is not clear the objective of improved safety is best met only via sticks and no carrots.
- *Within variation over between* — really we want to incentivise individual institutional safety and quality improvement, this may not be best done through comparative funding changes. Need incentives that reward all improvement, not just punish (comparative) underperformance.

For consideration in the implementation: In principle, pricing and funding models for safety and quality could be applied broadly in this manner. However, given the nature of the items on the lists of sentinel events and hospital acquired complications (HACs) and current approaches to coding patient data, models should initially be limited to admitted patient services.

It would also be appropriate to limit the model to ABF hospitals rather than block funded hospitals. Given that block funded hospitals are not directly funded on an NWAU basis, it would not appear appropriate to reduce funding based on any adjustments to NWAUs to reflect safety and quality.

The quality of condition onset flag (COF) data is a consideration, and it would appropriate to focus on ABF hospitals in terms of improving data quality.

The measures described all primarily relate to the inpatient setting. This will miss hospital acquired conditions (HAC) that originate in non-admitted patient settings, but are acutely managed in the inpatient setting.

For example, endoscopies done in the non-admitted patient setting where there is a post-operative haemorrhage or cardiac arrest and the patient is then admitted for the acute treatment of the haemorrhage/cardiac arrest. These conditions will be coded as present on admission and therefore not be captured by the proposed methodology. The same can be said for urology non-admitted patient care where the patient develops a urinary tract infection that progresses on to sepsis. This will not be captured as a HAC as it was present on admission for the inpatient admission though the non-admitted

patient care contributed to this.

There are no community based measures included.

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

Queensland considers that the first consideration for risk adjustment application is how preventable is the element? If there is a high level or preventability risk adjustment should not be applied e.g. Never Events, 3rd and 4th stage hospital acquired pressure injuries.

Use of co-morbidities in a model indicates that for certain patient factors a patient is more pre-disposed to acquiring the outcome of interest. The question that needs to be asked when considering co-morbidities for risk adjustment is "if a clinician is aware that the patient has this comorbidity can anything be altered in the patient's care to ensure they don't experience the outcome measured". For instance, if a patient is severely obese, it could be argued that a stage 3 or stage 4 pressure injury is preventable for this patient if the clinicians apply appropriate measures to prevent the pressure injuries and the hospital has adequate resources to support clinicians e.g. bariatric equipment, staffing, etc.

Factors to consider for all (HAC and readmissions) models should be those that are clinically significant and statistically significant. This ensures the following:

- factors used in the statistical model make the statistical model efficient i.e. helps risk adjust more accurately
- factors used in the model are clinically relevant to the clinician i.e. there is recognition that factors (co-morbidities) that clinicians have no or little control of are accounted for in the model

There is a need to ensure that the risk adjustment factors used in a model are not the result of poor care. For example, length of stay is not generally a good risk adjustor to use in a model because it can be associated with poor practices within a hospital e.g. a patient who experiences a complication stays in hospital longer or processes aren't defined or adhered to i.e. timely administration of drugs. Another example would be if 'length of labour' was selected for third and fourth degree perineal tears. Whilst length of labour would be statistically significant and explain some of the variation in outcome rates of 3rd and 4th degree perineal tears, a lengthy labour is not clinically appropriate as interventions perhaps should have occurred earlier.

The model should take account of factors that are demonstrated to have a significant impact on the probability of an adverse event. The evidence in the consultation paper suggests age is a critical factor. Other relevant patient factors may include gender, admission status and comorbidities.

Specifically there are a number of factors that could be considered including:

- Care type changes where a HAC has been reported – what did the care type change to? For example; sub and non-acute care to acute care or acute care to palliative.
- Impact of multiple re-admissions – i.e. should there be risk adjustment if a single patient continually requires readmission – or should the adjustment be applied only once per single patient for a period of time.
- Patient non-compliance with medical treatment. There are instances where no matter how hard a

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	facility tries to ensure patient safety and quality of care, the patient themselves negatively impacts their care. For example, refusing to take medication for diabetes, not following dietary requirements, refusing pressure injury interventions. • Impact of private to public shift – if a patient have initiating episode of care in a private hospital and then present at a public hospital for subsequent treatment, who is accountable for the re-admission – the public or private facility? This is also the same for public to public facility readmissions. **MNT HHS:** Metro North HHS stakeholders have recommended the following factors be taken into consideration when risk adjusting pricing and funding models for safety and quality: • Patient complexity including comorbidities, specifically considering patients with multiple comorbidities • Funding adjustments across hospitals for transferred patients, for example regional to tertiary facilities • Chronic health conditions • Age • Gender • Socioeconomic status **SUN HHS:** Analysis needs to be done to determine what factors have significant impact on the safety and quality measures, the common ones are: age, comorbidities, admission type, admission source, discharge destination, post code etc. *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? (Section 11.4.5)* **MNT HHS:** Metro North HHS supports the proposed criteria and suggests that no additional criteria required consideration at this time. **SUN HHS:** There should be some link between pricing and outcomes, the challenge is trying to measure and validate with existing minimum data sets. QLD has developed some already and new data items eg. Smoking cessation. Perhaps Quality Improvements could also be used to incentivise or reward, rather than only funding penalties. Yes Queensland agree the five assessment criteria set out in the consultation paper are supported. In addition, it is suggested that funding certainty should be an additional criterion. LHNs/ hospitals should be able to calculate accurately the value of any funding adjustments based on their adverse events. A small change in adverse events should not result in a significant change in funding, e.g. by reaching a particular threshold. This criterion is relevant to Option 2 in relation to HACs – i.e. making funding adjustments on the basis of differences in HAC rates across hospitals. If this Option is applied: It is important that the thresholds for rates of HACs above which funding adjustments apply are known in advance and that LHNs/ hospitals can monitor their performance against these thresholds. If funding adjustments were applied to hospitals with risk adjusted rates in the top quartile based

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	on current year performance, hospitals would not be able to estimate the value of any adjustments until validated data is available for all hospitals (i.e. well after the end of the financial year). However, IHPA has advised that this is not the intention, and that thresholds would be established as part of the NEP Determination, based on historical data. This would enable LHNs/ hospitals to track performance against the threshold throughout the year. In addition, for a hospital close to the top quartile, a small change in performance could result in a significant change in funding. It may be appropriate to adjust funding at the margin – e.g. to adopt a sliding scale or to reduce the number of NWAUs only for those adverse events that exceed the threshold. It is also considered important that the risk is **Attributable** – any pricing /funding adjustment should reflect the action or inaction of the provider being penalized.
11.5	**Sentinel Events**: *Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?* *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?* *Do you agree with IHPA's assessment of this option (not funding episodes with a sentinel event)?* **MNT HHS:** Providing safe quality care is a priority and considering this, Metro North HHS fully supports this funding development. The Qld funding model has incorporated healthcare adjustments since implementation and as a result of this, Qld facilities recognise this is a crucial aspect of funding to ensure service delivery aligns with patient and organisational expectations. It should be noted however that any adjustments should be applied to funding and not pricing. Any adjustments should be calculated in the determination of the revenue, not the NWAU, otherwise accurate throughput analysis of patient acuity will be impacted. In regards to the proposal to include a sentinel events flag, Metro North HHS supports this proposal, however it should be noted that a clear process would need to be developed articulating who is responsible for recording this and what parameters are used for collection. In regards to IHPA's assessment of this option (not funding episodes with a sentinel event) - as outlined above Metro North HHS fully supports this funding development, however clinical staff have suggested that a partial funding model may be more appropriate where activities prior to the sentinel event are eligible for funding and funding is not provided for care that occurs after the sentinel event (including any corrective actions to address the sentinel event). **SUN HHS:** In regards to supporting the proposal to not fund episodes that include a sentinel event – Yes. Queensland is concerned that at least half of the sentinel events are not preventable. A few examples of non-preventable sentinel events are provided below: • Wrong body part - the event involved serious harm as a single stage tendon reconstruction using the

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	right Palmaris Longas tendon as a graft was planned; however the median nerve was harvested instead of the tendon. Upon review it was identified this occurred due to anatomical complexities. • Intravascular gas embolism - the event was a result of a faulty cannula. • Retained instrument – a part of a surgical instrument used in an operation fell into the patient's wound. It was not discovered until after the operation. The surgical instrument was faulty. Use of the current version of sentinel events definition would be heavily criticised by clinicians and hospital executive, potentially damaging the validity of the entire safety and quality funding initiative. It is nationally recognised that the current definitions of sentinel events are not robust, hence the work that has commenced to review the sentinel events definitions led by the ACSQHC. However, the ACSQHC anticipates that the review of sentinel event definitions won't be complete until July 2017 with jurisdictions to implement adjustments to their data collections systems to collect the revised version of the sentinel events. Queensland proposes one of two options: Option 1 – finalise the revised version of Sentinel events by July 2017, require jurisdictions to implement data collection tools by June 2018 and implement the sentinel event funding approach using the revised definitions on 1 July 2018. Option 2 – implement the funding approach for the current version of sentinel events 1 July 2017, but require hospitals to identify if each event was wholly preventable with their relevant jurisdiction given the jurisdiction's regulatory roles over hospitals. Each jurisdiction would then report to IHPA the preventable sentinel events which would be the only ones that would have the funding approach applied. The revised version of sentinel events would then planned to be introduced July 2018. In regards to supporting the proposal to include a sentinel events flag, the admitted patient data collection does not align and will never align with clinical incident data. There are four main reasons for this: • Incident data is categorised differently to admitted patient data collection • Admitted patient data collection requires coding within 30 days. The final incident outcome is not generally defined until after a complete investigation has occurred into the death or permanent patient harm which takes between 45-120 days depending on the jurisdictional requirements. Some may take longer if there are added complexities or reviews which more frequently occur in sentinel events. The incident system allows for the final outcome to be identified and recorded, whereas the admitted patient collections does not allow for this • Sentinel events are often not detected within the episode of care or aren't recognised within the episode of care. For example, some of the retained instruments are not detected until a few months or few years subsequent to the initial procedure. The incident system identifies when the incident is identified whereas the admitted patient data collection does not identify this. • Incidents can occur within the ED or outpatients. These aren't collected in ED or outpatient data collections consistently. In regards to assessment of this option (not funding episodes with a sentinel event) –yes, this makes sense at the consumer level. It would be more appropriate to not fund the entire separation (all episodes related to this incident, not just the one).

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	If implemented the proposal to not fund episodes that include a preventable sentinel event would appear reasonable, so long as IHPA back-casts for this measure. Queensland Health broadly supports the proposed model for sentinel events; • The sentinel events proposed broadly align with those already identified in Queensland and which have been in place since 2011.We foresee no issues with respect to their formal implementation at the Federal level (excepting the relatively small impact on the total pool of funding received) and would therefore support the implementation of non-payment for preventable sentinel events and use of a 'flag' system for data collection purposes. We do not think that risk adjustment is necessary as these 'never' events should not ever be occurring, regardless of variation in patient profiles or services. **Note that** the document does not clearly state that these events must occur within the current episode of care. Some "sentinel" events such as retained instruments or other material may not be identified for a significant period of time after the initiating event. Also the timing for reporting/capturing sentinel events may be impacted by processes such as the need for an autopsy (intravascular gas embolism and maternal death associate with pregnancy). This could mean that confirmation of a sentinel event may occur in a different financial year to the incident. In regards to IHPA's statement, 'Given the delays and incomplete nature of reporting on sentinel events through the Report on Government Services, IHPA is proposing that jurisdictions be required to apply a flag to any episode including a sentinel event. These episodes would be compared to the sentinel events identified by IHPA using ICD-10-AM codes. IHPA would consult with jurisdictions to ensure that all sentinel events are captured, prior to providing advice to the Administrator for funding purposes', SSSU comments that this is not in proposed NMDS for 17-18. If it can't be derived from the data by IHPA, how are jurisdictions supposed to derive it? For the rare events, no justification for adding a data element to each record. Comment on table on page 35 '*IHPA assessment: No funding for episodes with a sentinel event*' and criteria '*Ease of implementation – Partial'*, there would be some initial work to flag and agree episodes with a sentinel event. We believe that this may be an understatement of the work required.
11.6 **11.6.1**	**Hospital Acquired Complications** **Scope and definition of HACs** In regards to the detailed specification of the final list (excel file) of 16 HACs, which includes the relevant ICD-10-AM codes, available on the Commission's website: Tab 1 HACs List (1. Hospital acquired complications list) under Complication: *1 Pressure injury:* As L89.9- *Pressure injury, unspecified stage* has been included, it is appropriate to also include L89.5- *Suspected deep tissue injury, depth unknown, so stated* as this is also a clinically significant pressure injury. Also, as per above comment (COF also does not accurately reflect conditions that worse during an episode of care. For example if a patient presents with a stage 1 pressure injury that progresses to stage 4 during the episode of care, the COF is "2 – condition present on admission"). This means that this HAC will not identify all pressure related injury harm occurring in hospital. *8. Renal failure - 8.1 Renal failure requiring haemodialysis or continuous veno-venous haemodialysis –*

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	suggest inclusion of U87.1 Chronic kidney disease, stage 3–5 as an exclusion. *10. Medication complications - 10.3 Hypoglycaemia* – as per above comment that this does not take into account patient non-compliance. Note for Tab 1: ICD-10-AM/ACHI Tenth Edition codes should be included in this document (7th edition was used). Tab 2 – HACs – Perineal Laceration (2. Complication 15 'Third and fourth degree perineal laceration during delivery'): While there is a note on Tab 1 that this complication requires a COF code of 1 (Condition with onset during the episode of admitted patient care), this detail is not included on Tab 2. If the delivery does not occur in hospital it should not be included. The information on Tab 2 does not clarify this. Note for Tab 2**:** ICD-10-AM/ACHI Tenth Edition codes should be included in this document (7th edition was used). Tab 3. HACs – Neonatal birth trauma (3. Complication 16 'Neonatal birth trauma'): The detail for this complication does not currently include the requirement for the COF to be 1 (Condition with onset during the episode of admitted patient care). While it does note that transfers are excluded, it does not currently include out of hospital delivery. If a newborn is delivered outside of hospital and sustains neonatal birth trauma, the COF would be 2 and should be excluded. Note for Tab 3**:** ICD-10-AM/ACHI Tenth Edition codes should be included in this document (7th edition was used). **Option 1: Remove the HAC so that it does not contribute to DRG assignment (remove 'high-complexity' from the final DRG to reduce payment for that separation)** *What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC? Do you agree with IHPA's assessment of option 1?* **MNT HHS:** Metro North HHS agrees with IHPA's assessment of this funding option (option 1). If the funding variation would only apply in a minimal amount of episodes, there is little benefit to be achieved in adopting this option. It's also likely that the small number of episodes which do result in a DRG change are more complex and warrant additional funding. Thus, this option appears to restrict funding to episodes that cost much more, whilst not creating an overall impetus to focus on reducing these avoidable complications. **SUN HHS:** Advantage: It is directly linked to a patient episode that can then be analysed to put improvements in place. Disadvantages: the HAC may not be risk adjusted if it is applied as a straight adjustment across all episodes. Queensland has identified Disadvantages: This funding approach only applies to 15 % of the HACs. It is unclear if the 15% that the funding approach applies to are preventable. It is unclear to the clinician if the HAC that occurs is a HAC that will have the funding reduction applied. The approach does not adequately address preventability of each HAC. The approach does not adequately risk adjust for each HAC. In most cases, hospitals do not currently receive any additional funding for episodes that include a HAC,

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	even though they are likely to incur additional costs, because the presence of a HAC does not affect the DRG to which the episode is assigned. However, in some cases the HAC means that the episode is assigned to a higher complexity DRG and hence the hospital receives additional funding. Under Option 1, the HAC would not contribute to DRG assignment so the hospital would still be funded based on the lower complexity DRG. In general, this would appear to be an appropriate outcome. However, one disadvantage is that there would be no risk adjustment. Hence the model would not make any adjustments for the higher risks associated with some patients and episodes, or for the fact that such patients and episodes are not distributed evenly between hospitals. This would not appear to be consistent with the approach envisaged in the Heads of Agreement. It should also be noted that the current ABF model arguably disadvantages those hospitals that have higher rates of HACs because of higher risks arising from their patient cohort and casemix. In the majority of cases, these hospitals do not receive any extra funding to compensate them for their higher rate of HACs, because the presence of the HAC does not affect the assignment of DRG and hence does not affect funding. Implementing Option 1 without risk adjustment may increase this disadvantage. If this option is proceeded with, it would be appropriate to: • Undertake a detailed analysis of projected impacts at the hospital level, including the extent to which impacts by hospital vary based on factors that affect risk of a HAC, such as age of the patient cohort and hospital casemix. • If impacts at the hospital level differ systematically by factors that affect risk, consider how risk adjustment could be incorporated into the model. Consideration would need to be given as to whether risk adjustment would be at the hospital or episode level. Option 1 appeals due to its simplicity and transparency. It is notable that at present, a significant majority of episodes involving a HAC are not allocated a more complex DRG due to the presence of a HAC, and as such do not receive additional funding (assuming they are within the inlier range) even though they incur additional costs because of the HAC. This would appear to be an appropriate principle, and the implementation of Option 1 would ensure a consistent approach across all episodes by ensuring that episodes involving a HAC do not receive additional funding. However, a shortcoming of this approach is that it is not risk adjusted, so hospitals with a more complex patient profile or casemix would potentially be disadvantaged. Unless it can be demonstrated empirically that this is not the case, an approach to risk adjustment at the episode or hospital level would need to be developed. Queensland Health also understands that NSW has developed an alternative option which adjusts for safety and quality at the episode level. Under this option IHPA would reduce the price weights for all episodes that include a HAC within a particular DRG. However, the price weight for episodes without a HAC would be increased so that there would be no change to the level of NWAUs within a given DRG. This option appears to have a number of advantages and to be worthy of serious consideration. One key advantage is that it would effectively risk adjust for differences in casemix between hospitals. Casemix is also likely to be correlated with patient characteristics such as age and comorbidities, although further analysis would be required to determine if any additional risk adjustment is required. This option would also have presentational benefits, and would provide appropriate incentives for safety and quality at the level of the individual episode of care, but without affecting aggregate funding under the ABF model.

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	Option 2: Funding adjustments made on the basis of differences in HAC rates across hospitals (apply payment variations based on the overall hospital HAC rate *What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates? Do you agree with IHPA's assessment of this option? What are the advantages and disadvantages of the approaches to risk adjustment?* **MNT HHS:** Metro North HHS has concerns with this funding option and supports IHPA's assessment. Metro North HHS includes two tertiary referral facilities and accepts the most complex cases from across the state, interstate and the Pacific Rim; this funding option could potentially disadvantage the HHS due to the complexities and comorbidities of these patients. Implementation of this type of funding option would also require rigorous auditing of coding information. External benchmarking indicates there is a wide discrepancy between hospitals and reported hospital acquired infection rates; one Metro North HHS facility has been reported as having one of the worst rates in the benchmarking group, however internal analysis showed that this was the result of more thorough coding than other reported facilities. Metro North HHS recommends that coding practices be critically audited before this type of funding option is considered to ensure any funding adjustments are not influenced by poor coding practices as opposed to true performance around HACs. The approaches to risk adjustment do not take into consideration the size of the facility, acuity of casemix and the quality of coding, which would arguably impact larger facilities. Similarly, stratification of hospitals within states doesn't take into consideration these same variances. Metro North HHS supports the concept of stratification of hospitals within peer groups to provide a more equitable comparison between facilities. **SUN HHS:** As this is a high level adjustment, jurisdictions would need to be given detailed patient level data in order to know where the deficiencies are and where improvement is required. Hospital level adjustments would be preferable than at the LHN level. Ultimately the data needs to be made available so as to be able to implement improvement strategies. Queensland: Preferred options in 2 are stratification of hospitals within peer groups and risk adjustment. These two options allow for the impact of variations inherent in some patient cohorts. The assessment notes that the option achieves the goal of "Equitable risk adjustment"; this does not seem to occur with the approaches of "no risk adjustment" or "stratification of hospitals within states" as described on p45. These approaches do not allow for or take into account risk variations between patient cohorts. We agree that the two other approaches, stratification of hospitals within peer groups and risk adjustment, do meet that goal. Risk adjustment offers an opportunity to "level" or make allowance for differences between patient cohorts that could unfairly impact on some facilities. Advantages • This option is the only option that can accommodate different preventability rates for HACs. i.e. delirium may have a 20% preventability rate compared to 3rd and 4th stage pressure injuries which has a 90-95% preventability rate • this option accommodates the ability to risk adjust and account for patient factors beyond the control of the clinician where applicable • A hospital level approach allows for risk adjustment based on patient characteristics and casemix.

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	The reporting of hospitals' performance creates a reputation risk which is likely to have a strong incentive to avoid poor performance, in addition to the funding impact. Disadvantages • This model will require the most clinician consultation to develop the appropriate targets and risk adjustment, but will result in something that clinicians are more bought into as it would be more clinically robust • Would not recommend the use of rankings or league tables. Recommend either the use of a target set by clinical group or the use of statistical analysis / tools such as systematic variation. • relative ranking ensures that regardless of how well hospitals perform, the lowest ranking hospital will be penalized, even if it meets national standards. Any ranking should be absolute rather than relative, so that any hospital below a given benchmark would be penalized. The penalty need not be financial to stimulate practice improvement. The publication of national league tables would probably suffice. • If the penalty applies to the worst performing quartile of hospitals, there will be a significant funding impact to a hospital that only just sits within the quartile. • To adjust for this, consideration should be given to penalising only the HACs that exceed a specified benchmark HAC rate. The NWAU discount for episodes that exceed the benchmark may need to be set at a higher level to provide an appropriate disincentive – e.g. it would need to be higher than 10 per cent in the example provided by IHPA to have a similar funding impact. • The reporting of poor performing hospitals would create a further incentive to improve patient safety and quality outcomes. However, it could also create unintended changes to behaviour, such as shifting hospital resources away from activity associated with higher likelihood of HACs. In regards to the advantages and disadvantages of the approaches to risk adjustment for option 2: • It may be appropriate to use raw rates for HACs with high preventability e.g. 3rd and 4th stage pressure injuries • It would not be appropriate to use raw rates for HACs with a lower preventability rate and for complications that are highly influenced by risk factors that clinicians have no control over • Stratification of hospitals within a state would not be supported because this indicates that it would be ok to have differences in care between states and would not promote improvement for jurisdictions with a lower average • Stratification of hospitals within peer groups may be more acceptable for some complications where differences may exist in available resources, however this would need to be considered for each HAC as it may be suitable for one and not the other. IHPA has identified four alternative approaches to risk adjustment. • No risk adjustment – this would result in some hospitals being disproportionately penalised and would make the assessment of relative HAC rates between hospitals difficult to interpret. This approach is not supported. • No risk adjustment, stratification of hospitals within States – this would allow for differences in age and other health factors between jurisdictions, but may not take account of significant regional differences (eg, regional areas versus capital cities, or differences between regions). This approach is

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	not supported. • No risk adjustment, stratification of hospitals within peer groups – this is likely to provide a simple and transparent approach to equitably comparing hospital performance. However, it would depend heavily on the number of peer groups, and how these are defined. Significant differences in patient characteristics and casemix may still exist within peer groups. • Risk adjustment for age and patient complexity – this would appear to be the most thorough approach but the risk adjustment model would need to be worked through in detail. Hence Queensland supports risk adjustment for age, casemix and other relevant factors, on the basis that it is not likely that simple stratification of hospitals within States or peer groups will adequately capture differences in risk profile between hospitals. Nevertheless, the risk adjustment process is complex and will involve judgements as to which factors should be taken into account, the level of disaggregation, etc. It would be appropriate for a more detailed model to be developed in consultation with the Technical Advisory Committee. It should also be noted that the paper suggests that risk adjustment should not discount away or fully adjust for the higher risks experienced by some patients. It is not clear why this should be the case. • Hospitals should take all necessary action to manage risks and mitigate the occurrence of any adverse events for all patients, whether high-risk or low-risk. • Risk adjustment should not disadvantage hospitals that treat more high-risk patients compared to those that treat more low-risk patients. Option 2 appeals because only hospitals that exceed a particular threshold rate of HACs would have their funding reduced. Risk adjustment could be achieved by calculating a specific threshold for each hospital based on its patient characteristics and casemix, or by establishing thresholds for hospital peer groups and ranking each hospital within its peer group. This Option would also enable reporting of hospital performance, which is likely to provide as much of an incentive to improve performance as funding reductions. However, Option 2 is more complex than Option 1, and the risk adjustment methodology in particular would give rise to a range of technical issues. It should also be noted that a range of detailed issues would arise in implementing either Option 1 or more particularly Option 2. It is assumed that the final model will be developed through the usual consultative mechanisms, in particular the Jurisdictional Advisory Committee and the Technical Advisory Committee.
	Option 3: A quality-adjusted NEP with funding incentives for hospitals with the lowest HAC rates (providing lower overall price but then re-investing the gap as incentive payments to best performing hospitals) *What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties? Do you agree with IHPA's assessment of this option? Are there are other pricing options that IHPA should consider in relation to HACs?* **MNT HHS:** Metro North HHS supports the concept of incentives for better health outcomes. A concern in relation to all options is that although HACs may be a significant factor in DRG allocation for some episodes, any other comorbidities present may also influence the DRG and lead to a more complex DRG

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	being assigned, rather than the HAC being the sole cause of the higher acuity DRG. Metro North HHS does however have concerns with the proposal of the "quality-adjusted NEP". The model will reduce the NEP based poor performing jurisdictions, if the incentive funding does not offset this reduction then even if a HHS performs well in relation to their HACs, no additional benefit will be evident as the incentive will be offset by the funding reduction incurred from the reduced NEP. In regards to other pricing options that IHPA should consider in relation to HACs, Metro North HHS recommends that IHPA consider specific penalties (either as a percentage or specific amount) per HAC that aligns with the severity of the complication. **SUN HHS:** This assumes that episodes without HACs cost less and the costing systems across the jurisdictions are sophisticated enough to measure this. The financial impact of a HAC may lead to extended hospital stay or more diagnostic costs etc. Has the analysis been done to determine this? Funding incentives could be based around other measures aimed at reducing HACs rather than basing the whole penalty/incentive scheme on the HAC and its link to costs. Queensland considers that this model does not seem to offer risk adjustment or peer grouping; without this the hospitals with the lowest rates may be those with the lowest risk cohort. Removing all HAC from the calculation of a National Efficient Price (NEP) may lead to an artificially simplified assessment when there may be some episodes that will inherently raise the risk of complications. The option does not seem to meet the goal of "equitable risk adjustment" for the reason described at response to question 22. Disadvantages The absence of a targeted funding reduction that applies to episodes with a HAC would be unfair The funding approach does not accommodate different preventability rates between the different HACs It is unclear to the clinician if the HAC that occurs is a HAC that will have the funding reduction applied The approach does not adequately address preventability of each HAC The approach does not adequately risk adjust for each HAC This option does not meet the proportionality criteria as the methodology is too general in its approach i.e. doesn't target the specific preventable HACs. This is the least desirable option presented by IHPA. Option 3 appears to seek to achieve much the same end result as Option 2, but involves an additional layer of complexity. That is, all hospitals would be penalised through the reduction in the NEP, but then a portion of the reduced funding would be returned to highly performing hospitals to return them to a revenue neutral position. IHPA has assessed this option more favourably against the criteria than it has for both Options 1 and 2, but it is not clear why. Under Option 2, IHPA noted that the proportionality criterion was only partially addressed as it requires an estimation of the quantum of the funding adjustment and how it will be applied. It is not clear why the same qualification should not apply when assessing Option 3. As noted in the consultation paper, the reduction in the overall NEP means that the funding adjustments are not specifically targeted to episodes with HACs. This is a very blunt instrument that would not provide appropriate pricing signals at the hospital or departmental level. While some funding would be returned to individual States and Territories, there would be no direct mechanism to incentivise individual

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	LHNs or hospitals for good safety and quality, and jurisdictions would need to develop their own mechanisms. It could also be argued that Option 3 over-adjusts by removing all episodes with HACs from the calculation of the NEP. This implies that all HACs are avoidable, which is clearly not the case. Only for the highest performing hospitals would funding be returned. Other hospitals would not receive any funding to reflect the additional cost of HACs, even though some HACs are unavoidable. Option 3 would also appear to be problematic in terms of back-casting. In particular, it would not appear possible to express the value of the adjustments for safety and quality in terms of NWAUs. This would make it more difficult to back-cast for the changes to the model.
11.6.8	**Responding to Condition Onset Flag data quality issues** *How should IHPA treat hospitals with poor quality COF reporting* **MNT HHS:** Metro North HHS supports the proposal that hospitals with poor quality COF reporting be subject to funding reductions that would be the same as hospitals (with good quality COF data) that had HAC rates in excess of the threshold for funding adjustments. It should be noted however that COF is a mandatory reporting requirement and facilities which cannot supply quality COF data should be identified and targeted strategies to improve mandatory reporting requirements established; if there is continual poor performance in this area then financial penalties could be considered. **SUN HHS:** The hospitals that are known for poor reporting of COF should be financially penalised, and audited on a regular basis until data quality improves. Otherwise they do have an unfair advantage that could lead to the intentional under-reporting of COF. Queensland notes that a number of hospitals were excluded from this analysis due to poor quality COF reporting. • Poor quality COF reporting could be penalised. • COF of “unknown” should be assumed as COF – present Provide incentives for hospitals with good quality COF reporting. An alternative may be a base line NEP, based on the “quality adjusted” NEP described in option 3 for hospitals with poor COF Hospitals with poor quality reporting should be excluded for in modelling but not be excluded from being held to the model (i.e. they should be paid by the model but not be part of how the model is created). A data quality audit plan would be required to support the implementation of the pricing for Quality and Safety using the COF. COF also does not accurately reflect conditions that worsen during an episode of care. For example if a patient presents with a stage 1 pressure injury that progresses to stage 4 during the episode of care, the COF is “2 – condition present on admission”.
11.7 **11.7.2**	**Avoidable hospital admissions** **Definition of avoidable hospital readmission** **SUN HHS:** This indicator is problematic as it refers to readmissions to the same public facility.

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	Readmissions occur at other facilities within the same local health network or potentially across health networks. Without a unique identifier for each patient it makes this difficult to measure [on an ongoing basis within the State]. The definition of "unplanned" and "unavoidable" are measures not captured. QLD measures particular conditions using a VLAD (variable life adjusted display) as well as mortality ratios using VLAD. Queensland notes that '*2.Unplanned hospital readmissions for selected surgical procedure. Status: This indicator is currently being measured and reported by the AIHW. It clearly represents a subset of avoidable hospital admissions as it is limited only to those following a surgical procedure and it excludes all readmissions after medical admissions'* – this is not at all robust. The working party still hasn't come to an agreement. Readmissions to same hospital only are meaningless. *What approach is supported for setting timeframes within which avoidable hospital readmissions are measured?* **MNT HHS:** Metro North HHS supports varying the measurement period according to the clinical condition and any supporting evidence in the timeframes in which complications might be expected to occur. However, caution should be applied for some categories, for example stage 3 and 4 pressure injuries may progress where the facility has no ability to oversight the care and recovery of the patient once discharged. **SUN HHS:** Should be condition specific. In Queensland unplanned readmissions within 7, 14 and 28 days are measured. Representations to the emergency department within 48hours are also measures. It is also worth considering if the measure should be targeted at unplanned representations for the same DRG. The use of the same DRG is a stronger measure of preventability. However, there are currently no clinically robust readmissions indicators that have been developed for the intention of funding or pricing approaches. Readmission timeframes should always be determined as what is clinically appropriate for the condition admitted / surgical procedure performed and the reason for readmission: • *Example 1 – for a patient who had a tonsillectomy - a readmission for post-operative bleed within 5 days could be linked to issues related to safety and quality of care. A Post-operative bleed between 5 and 30 days is unlikely to be related to safety and quality of care.* • *Example 2 – for a patient with a hip replacement – a readmission for a DVT within 30 days could be linked to issues related to safety and quality of care issues.* The direction to IHPA on the performance of its functions under section 226 of the National Health Reform Act 2011 defines an avoidable hospital readmission as: avoidable hospital readmission means readmission to hospital within 28 days of discharge, with a particular focus on avoidable readmission within 5 days of discharge, for a condition or conditions arising from complications of the management of the original condition. On the basis of this direction it would seem prudent to apply the pricing and funding model to avoidable readmissions within 5 days of discharge, at least in the initial phases.

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	Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes? **MNT HHS:** Metro North HHS key stakeholders have indicated that they are not aware of any formally endorsed timeframes. **SUN HHS:** Mental Health episodes have guidelines in place. Queensland notes that The Australian Commission of Safety and Quality has core, hospital-based outcome indicators (CHBOI). One of the CHBOI groups relates to unplanned/unexpected hospital readmission of patients discharged following management of: a) acute myocardial infarction (AMI) b) knee replacements c) hip replacements d) paediatric tonsillectomy and adenoidectomy https://www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/ There should also be consideration of linkage between non-admitted episodes of care to inpatient episodes of care. *Is there support for pricing and funding models to be based on avoidable hospital readmissions with the same LHN?* **MNT HHS:** Metro North HHS suggests that this proposal proceed with caution. Hospitals may be penalised based on clinical coding in other facilities. The facility penalised should be given the opportunity to review the cases when adjustments are incurred, based on data from other hospitals. Considering this, Metro North HHS believes it would be extremely complex to manage and administer this model. **SUN HHS:** As mentioned the Medicare Number has not proven reliable as a proxy for a unique identifier in the past, significant work in improving the reliability of this field would be required or identifying a different field or external linking algorithm (such as QLD's client directory). In Queensland readmissions are not able to be measured easily across a Hospital Health Service/LHN due to multiple patient identifying numbers. Currently readmissions are only measured by hospital and clinicians note that this does not capture all episodes. • National (AIHW and NHPA) and Queensland studies have identified that variation in the % of hospital readmissions back to the same hospital can vary significantly between hospitals. • Patients who have experience safety and quality issues on an initial admission will often seek care at a different hospital if they are able to choose so

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	The principle should be that readmission is attributable to action/inaction of discharging hospital therefore timeframe should be short 5 days and in this instance we would support the pricing and funding models being based on avoidable hospital readmission within the same LHN. It is paramount that any implementation adequately supports safe discharge practices (e.g. for those short term admissions who have not had a HAC diagnosed but are being discharged earlier than clinically ideal or without adequate support in place) and would address only a small amount of cases, as would surgical only. A list of defined diagnoses may provide a more transparent and comprehensive option and could be made broad enough to have a meaningful impact on the quality of patient care. Implementation of a pricing and funding approach should learn first from sentinel events and HAC implementation. *When should a pricing and funding approach for avoidable readmissions be implemented?* **MNT HHS:** Metro North HHS supports the establishment of a pricing and funding approach for avoidable readmissions and recommends that implementation occur once the model is developed and undergone appropriate consultation across the jurisdictions and relevant clinical groups. Queensland considers that a rigorous process needs to occur to define clinically and statistically reliable indicators. Once determined, the indicators should be pilot tested for at least a year and that the answer to this would depend heavily on the definition of avoidable readmissions. If it was agreed there needs to be a comprehensive listing of unplanned readmissions, then it would take a considerable period to implement. IHPA has outlined narrower definitions including unplanned readmissions for selected surgical procedures, or readmissions causally related to an initial admission involving a HAC. Even assuming a relatively narrow definition of avoidable readmissions, it would be appropriate to undertake a process of clinical engagement to determine the scope of readmissions that are considered to be avoidable. It would not appear to be feasible to consider the implementation of a pricing and funding approach for avoidable readmissions before 1 July 2019 at the earliest, assuming a shadow year prior to implementation. And/or – and until there's some estimate of the proportion of responsibility of an LHN (vs a PHN) is conceptually questionable.
11.8	**Implementing a pricing and funding approach** *What do you think are the most important considerations for implementation of pricing and funding approaches for safety and quality?* *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?* **MNT HHS:** Metro North HHS fully supports integration of safety and quality into the pricing and funding models. The approaches proposed by IHPA reflect a considered response to these funding model developments. Metro North HHS considers it important that any model changes associated with safety and quality are fair, transparent and achievable. A broad consultation plan is imperative to ensure jurisdictions can be afforded the opportunity to review, analyse and potentially challenge the data sets. It is also important that tertiary referrals hospitals that treat a highly complex casemix are not negatively affected due to their casemix as opposed to poor safety and quality. In principle, Metro North HHS supports back-casting any changes to pricing and funding models as a

result of the introduction of safety and quality measures. However, for any new reporting categories with penalties attached, LHNs should have reasonable lead time to prepare for implementation.

SUN HHS: Regarding the most important considerations for implementation of pricing and funding approaches for safety and quality - use penalties for poor outcomes but incentives for evidence-based activities aimed at improving health outcomes.

In regards to agreeing that IHPA would need to back-cast the impact of introducing new measures for safety and quality into the pricing and funding models - not necessarily if a baseline year was nominated prior to the introduction and jurisdictions had time to implement new data collection systems if required. Back casting won't work if new data is to be collected or the quality of current data items is poor. A "base/shadow" year could be introduced where no links are made to the funding until subsequent years.

Queensland

- Ensuring there is a good level of preventability in the measures
- Ensuring the indicators are clinically relevant and reliable
- Ensuring the indicators are developed in consultation with consumers, clinical, quality, statistical and coding experts
- Ensuring that if a penalties approach is applied clear clinical actions are identified to prevent the outcome occurring

Queensland Health considers that most of the important considerations for implementation of pricing and funding approaches for safety and quality are set out in the Direction to IHPA dated 29 August 2016 from the Commonwealth Minister for Health and Aged Care. In addition, the approach should create a financial incentive at the hospital or episode level that seeks to encourage continued efforts to improve patient outcomes, but overall Commonwealth public hospital funding should not be adversely affected.

It is therefore critical that IHPA back-cast for the impact of new measures for safety and quality.

In inter-jurisdictional discussions on pricing and funding for safety and quality, all jurisdictions including the Commonwealth have accepted that the use of financial levers for safety and quality should not be a mechanism to reduce the Commonwealth's contribution to hospital funding, and that any reduced Commonwealth funding as a result of improved safety and quality should be reinvested to maximise funding for delivery of quality improvements and high quality outcomes for patients.

The challenge therefore is to ensure that adjustments provide appropriate incentives for safety and quality at the level of the individual episode of care, while minimising any impacts on the overall level of Commonwealth public hospital funding.

This would largely be achieved so long as IHPA and the Administrator apply the usual approach to back-casting, which would ensure that, any adjustments for safety and quality in the model would apply to both base year NWAUs and current year NWAUs.

This requires that any adjustments for safety and quality are expressed as reductions in the number of NWAUs. This would appear to be relatively straightforward under the IHPA proposals for sentinel events, and under IHPA's Options 1 and 2 for hospital acquired complications.

As noted above, this approach to back-casting is business as usual for IHPA and the Administrator. For instance, the IHPA back-casting policy states that for calculating the actual growth in Commonwealth funding, the Administrator should apply the current year price weights to the previous year's activity data,

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	to ensure that methodological changes in the national pricing model are accounted for. Under this methodology IHPA would calculate State and Territory back-casting multipliers for the Administrator to apply in calculating efficient growth. The Administrator would initially apply these multipliers in determining funding through the year. Under the final reconciliation process, the Administrator would apply the current year national Activity Based Funding (ABF) model, including any adjustments for safety and quality, to base year public hospital activity data to calculate base year NWAUs for the purpose of finalising the calculation of Commonwealth growth funding. For example, in calculating Commonwealth growth funding for 2017-18, the Administrator would apply the N1718 model to activity data for both 2016-17 and 2017-18. This would reduce the level of NWAUs for both 2016-17 and 2017-18 in line with any adjustments for safety and quality, but would not have a systematic effect on growth in NWAUs. As such, any adjustments for safety and quality would have only a minor impact on aggregate Commonwealth funding at the State or Territory level. However, the adjustments would still have an impact on payments for individual episodes of care and potentially on the allocation of funds between LHNs. As such, the model would incentivise good safety and quality at the LHN level (as well as at the level of the hospital and the individual department within a hospital), while largely preserving aggregate funding at the State or Territory level. This would appear to meet the objective of the reform. The importance of back-casting is shown in Table 1 below: It is assumed that following amendments to the national ABF model, the effect of safety and quality adjustments is to reduce NWAUs by 1 percent in 2017-18 with no change to the 2016-17 baseline. In the absence of back-casting, the impact of the safety and quality adjustments would be to reduce ABF funding in 2017-18 by $22.8 million in this example compared to what it would otherwise have been, due to the growth in NWAUs falling from 40,000 to 29,600. However, if the base year NWAUs are also adjusted downwards in accordance with the back-casting policy, ABF funding is only $1.2 million lower than in the base case where there are no adjustments for safety and quality.

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Table 1: Safety and quality adjustments – Impact of back-casting

			Safety and quality adjustment	
	Units	Base Case (no safety and quality adjustment)	No back-casting	With back-casting
2016-17 NWAUs	NWAUs	1,000,000	1,000,000	990,000
2017-18 NWAUs	NWAUs	1,040,000	1,029,600	1,029,600
2016-17 NEP	$	4,807	4,807	4,807
2017-18 NEP	$	4,879	4,879	4,879
2016-17 ABF	$M	3,000.0	3,000	3,000.0
Price growth	$M	32.4	32.4	32.1
Volume growth	$M	87.8	65.0	86.9
2017-18 ABF	$M	3,120.2	3,097.4	3,119.0
Growth in ABF	$M	120.2	97.4	119.0
Difference to Base Case	$M	-	(22.8)	(1.2)

Nevertheless as shown in Table 1, while applying back-casting would significantly reduce the impact of adjustments for safety and quality on aggregate funding, it would not eliminate the impact completely. This is because of both a lower price component and a lower volume component. The change in NEP is applied to a lower number of 2016-17 NWAUs once the safety and quality adjustments have been made (price component), and the change in NWAUs is marginally lower in absolute terms (from 40,000 to 39,600 – volume component).

To avoid this problem, it would be possible to combine pricing and funding approaches in addition to back-casting to ensure that aggregate funding under ABF is not affected by adjustments for safety and quality. The simplest way to do this would be to calculate National Average Cost as total cost divided by the number of NWAUs, with the number of NWAUs calculated after any adjustments for safety and quality. This would lead to a slightly higher NEP than would otherwise be the case.

As such, episodes that did not meet safety and quality standards would receive less funding under ABF.

However, this would be offset by the fact that episodes that achieved safety and quality standards would receive slightly more funding than would otherwise be the case as a result of the higher NEP.

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	This approach could be combined with the proposed approach for sentinel events, or with either Option 1 or Option 2 (but not Option 3) for HACs. Under this approach, aggregate funding would be unchanged as a result of the introduction of adjustments for safety and quality. Another benefit of this approach is its presentation value at the clinical level, i.e. episodes that did not meet safety and quality standards would receive a reduction in funding whilst episodes that did meet the standards would be incentivised as they would attract a higher level of funding at the individual episode of care level. Critically any model needs to ensure that hospitals are not incentivised to turn away complex/high risk patients.