Response to the IHPA public consultation on the 2017-18 pricing framework.

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Dear IHPA Secretariat,

We are a group of clinicians with a particular interest in the care of patients with cognitive impairment in the acute hospital system. As indicated by the Consultation Draft for the National Safety and Quality Health Service Standards Version 2 it is clear that, as a nation, there is a will to better manage the risks to patients with dementia, delirium and other causes of CI.

Funding, along with these new standards are important driver for change. It is important therefore that the funding option chosen promote good care for patients with cognitive impairment the drivers for which may differ from more targeted risks.

The comments below we hope are helpful to your deliberations. We would be willing to clarify any questions you have. We have limited our input to Section 11 as this is the relevant section.

These comments represent our views and not those of the institutes or organisations we work for.

Consultation Questions-

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?

Price/cost signals are one of three essential elements in achieving sustained change in any health services (hospitals and any patient care settings). The other two are: standards, and an understanding that change is possible (and necessary).

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

The IHPA should be aware that improvements in S&Q require significant culture and systems change during which time there may be implementation costs without substantial change in adverse events. Improved S&Q often requires ongoing investment to be maintained. Our experience with the Dementia Care in Hospitals Program suggests that the appointment of a Clinical Nurse Consultant is essential to program sustainability. The health “savings” made

when harm is minimised should in part be re-invested in the system modification that has delivered that change. This is especially so when the system is low in technology change but high in human change.

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?

These criteria are useful when there is a clear link between the intervention and the AE being avoided. However, defining a program benefit using these criteria may be more difficult when the AEs avoided are not so clearly aligned.

For example, delirium may or may not have been preventable – however the prevalence should be monitored to determine changes in effective management and prevention, but perhaps without punishment for occurrence.

However, similarly, 'risk adjustment' practices for people with dementia and cognitive impairment on admission should be higher. If the tool is too blunt it may punish occurrence of delirium unreasonably; but if the tool is too soft it will not encourage practice change to reduce the preventable delirium rates.

Given that 30% of hospitalisations include cognitive impairment, this is a crucial area for cost pricing signalling in responding to patient risk with quality and safety practices.

The Dementia Care in Hospitals Program targets screening for and awareness of cognitive impairment, with the objective of reducing the rate of a suite of AEs These include UTI, pneumonia, pressure injuries and delirium, and are being used to evaluate the national implementation. It is hoped such programs, which may increase the identification and documentation of events such as delirium, while also decreasing the clinical rates, will not be disadvantaged.

A key component of this will be consistency in coding practices. Currently cognitive impairment can be coded as R418, for example, which is used twice as often in hospitals with high Cognitive Impairment identification compared to other hospitals.

Other assessment criteria regarding approaches to funding that should be considered (in addition the transparency and preventability etc listed on pages 30 and 31) is an 'equitable efficiency adjustment'.

Efficiency is different in different kinds of hospitals; but this should not be at the cost of quality and safety. Hospitals being 'one-size-fits-all' may not achieve efficiency in surgery, for example. Factory lines with multiple item creation are less efficient that those with single-item deliverables. Safety and quality may have greater costs for services/specialties/care needs that are infrequently delivered, partly due to throughput, demographics and sheer volume of types of patients to achieve critical mass and efficiency. Hospitals with demographics that are higher in aged populations may be more effective in quality and safe care for delirium.

How should IHPA treat hospitals with poor quality COF reporting?

An audit of COF rates for specific DRGs should be undertaken. We are aware from our own analysis that some hospitals have low rates of COF when compared to the Y9222 flag in their data and this indicates poor COF coding. By identifying those low COF hospitals remedial action can be taken prior to the introduction of the pricing for safety and quality initiative. For those hospitals with persistent poor COF reporting, they could be excluded from any benefits in Funding Option 3. Another approach would be to audit the poor coding hospitals, at their expense, until a satisfactory level of coding is achieved.

In our experience the COF degrades the AE data substantially. We compared the Needleman approach to the COF for data set from 2014/15 and found when using the COF, the overall rate of complications fell from 20% to 6% for all episodes and 43% to 10% for episodes with a cognitively impaired patients. The COF should be further developed for accuracy of coding.

A two-stage approach with 'clearly hospital-acquired AE' and 'potentially hospital-acquired AE' or 'incidentally-acquired AE' may encourage monitoring and adaptation without price-punishment consequences when the 'fault' of the outcome is less clear. However, 'incidentally-acquired' still indicates a higher care need during hospitalisation, which should be encouraged to be delivered.

Which Funding Option?

With only a clinicians understanding of funding it seems that Option 3 might be better for the complex patients in geriatric medicine practice. This would support hospitals with a broad S&Q approach that is required to change outcomes where multiple different risks from the often multiple comorbidities that exist in one patient. The risk-adjustment approach would need to be comprehensive though, and include: comorbidities, age, and functional ability/dependency (independent and self caring is a different risk profile to being 'full nursing care').

We think Option 3 actually best addresses the difficulty that change needs a whole-of-system approach. Option 3 offers greater incentive, rather than only punishment, to engage this.

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

This is an important measure as the elderly are often moved across multiple hospitals. Is it possible to add the private sector as patients are often moved to the public sector after private sector complications and re-admission to the private sector for older people is not uncommon?