Mr James Downie
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Dear Mr Downie,

I am writing on behalf of Children's Health Queensland Hospital and Health Service (CHQ) in response to the Independent Hospital Pricing Authority (IHPA) consultation paper on the pricing framework for Australian hospital services 2018-19.

CHQ recognise that individual Queensland Hospital and Health Services and the Department of Health (DoH) may also submit separate responses to the consultation paper.

The response below represents consultation with key stakeholders within CHQ regarding the pricing framework specific for tertiary children's or paediatric hospital services.

Consultation Question	CHQ response
Section 4.3 Australian Refined Diagnosis Related Groups	
What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?	None at this time.
Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?	Yes
What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?	Private hospitals and health funds to advise.
Section 4.5.1 Multidisciplinary case conferences where the patient is not present	
Do you support the proposal to shadow price non-admitted multidisciplinary case conferences where the patient is not present for NEP18?	CHQ supports the proposal to shadow price non-admitted multidisciplinary cases conferences where the patient is not present; however it should be noted that the administration, counting and costing of this activity will likely be problematic for hospitals and health services.

Consultation Question	CHQ response
Section 4.5.2 Home ventilation	
Do you support investigation of the creation of multiple classes in the classification for home ventilation?	Yes, CHQ believe there are significant model of care and cost differences in the current definition of non-admitted home-delivered ventilation class. The investigation should also include a review of the services and models of care provided to paediatric patients in comparison to adult patients.
Section 4.8 Australian Mental Health Care Classification	
What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?	How to break the age range down for Child and Adolescent Mental Health Services, (CAMHS) to better reflect complexity of assessment, treatment and support i.e. 0-5, 6-12 and 13 – 17. It is currently 0 - 17 • The lack of outcomes for the infant 0 – 3 age range – (the Health of the Nation Outcome Scale – Infant (HONOS-I) is under development but not yet operational). Queries re: how the complexity and intensity of work within perinatal and infant mental health is captured in a classification system. • Inter-rater reliability for HONOSCA and does this outcome measure capture psychosocial complexity – should the FIHS and CGAS be re-looked at to better reflect these domains • How to ensure costing models capture the complexity of working with families (blended and intact) and not just an individual with a mental health issue • How to ensure costing models capture the systemic work CAMHS routinely undertake such as inter-agency work with child protection, education etc. • How to best classify CAMHS diverse models of care, i.e. day programs, assertive outreach, acute response teams, forensic and consultation liaison teams • How will the Phases of Care be interpreted for CAMHS – for example where would an eating disorder episode of care fit in? Is there any uniformity in our application of these Phases – is it more complex in CAMHS due to our systemic approach to care? (Vignettes are under development to test translation into practice out for CAMHS and also provide participating services with an opportunity to test inter-rater reliability- we have not had any feedback on the implementation of this initiative). • Is there a need to repeat the mental health costing study with a focus on CAMHS as it is debatable whether the one undertaken was representative? **Age Range Breakdown** How to break the age range down for CAMHS to better reflect complexity of assessment, treatment and support i.e. 0-5, 6-12 and 13 – 17, 18-25. It is currently 0 – 18. Is there any different or alternate views, as some of the services go up to 25? Discussion overview: • Break down is critical especially with early childhood. • 18-25 huge group. To make it 12-25 is too large, 18-25 gives that transition to adolescent to adult

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	service. • Depends on purpose of the age grouping - if considering homogenous. Depends on the phases of care. HONOSCA is 0-3 yrs. • Need to consider with age splits, IHPA would require evidence of substantial levels of care which changes the cost profile. The classification is inclusive of mental health in all settings. Recommendation: 1. 0-5, 6-12, 13-17, 2. 18-25 if you have a model of care caters for this group. Note this age group could alter the funding. **Complexity** The lack of outcomes for the infant 0 – 3 age range – (the Health of the Nation Outcome Scale – Infant (HONOS-I) is under development but not yet operational). Queries re: how the complexity and intensity of work within perinatal and infant mental health is captured in a classification system. Inter-rater reliability for HONOSCA and does this outcome measure capture psychosocial complexity – should the FIHS and CGAS be re-looked at to better reflect these domains Discussion overview: • Z codes - considering the in complexity, especially if using HONOSCA. • HONOSCA is better when high volume but not individual. Individual level CGAS. • Z codes depends on weighting. • Second Costing Study - Actual Child & Adolescent (C&A) mental health services for the trialling of the classification system. The services for the initial costing study were inadequate but it should be noted that they would have been nominated by the State department of health. Recommendation: 1. Second Costing study of C&A Mental Health Service – both large and small. (Considering MOC and service provider activity ensure the full range of complexity.) 2. Z Codes - Need to understand the difference of HONOSCA and CGAS, FIHS re the sensitivity of change, therefore need to include Z Codes **Interagency work – capture from costing perspective** How to ensure costing models capture the systemic work CAMHS routinely undertake such as inter-agency work with child protection, education etc. Discussion overview: • Costing perspective to identify work – if you don't hold the client. • Systematic case management – non face to face • Supportive work – team that facilitate the work or others that work directly with the patient.

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	• Would IHPA see this work as costed work? How do we reflect this work into the breakdown? Speciality teams. • How do we get this recognised – case example variety that exemplify the level of work and care across those groups. • Phases of care – what does acute mean for the different levels of care for C&A Recommendation: 1. Phases of care in relation to C&A clear, consistent definitions which will provide clarity. **Capturing costing of support provided to family of the child** How to ensure costing models capture the complexity of working with families (blended and intact) and not just an individual with a mental health issue.
Section 6.1 Pricing mental health services	
Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?	Issues identified above need to be addressed prior to any implementation of ABF for mental health services. Currently the phases of care are not sensitive to the acuity or the systemic nature of the mental health presentation, nor do they distinguish between the multiple speciality areas.
Section 6.3 Stability of the national pricing model	
What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?	No comment at this time.
What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.	No comment at this time.
Section 9.1.1 Transferring services from ABF hospitals to block funded hospitals	
Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?	Yes, to ensure the integrity of the ABF and block funded models is maintained.

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If so, how should this be carried out?	Further investigation to determine patient volumes and materiality.
Section 9.3.1 Residential mental health care services	
Do you support IHPA's proposal to continue to block fund residential mental health care in future years?	Yes, CHQ support the continuation of block funding and are not confident that the pricing mechanisms are robust enough to rely on ABF funding for these facilities.
Section 10.7 Next steps	
Do you support the proposed bundled pricing model for maternity care?	No comment, service not provided by CHQ.
Do you agree with IHPA's assessment of the preconditions to bundled pricing?	No comment, service not provided by CHQ.
Section 11.4 Value-based healthcare	
What issues should IHPA consider when examining innovative funding model proposals from jurisdictions? Should IHPA consider new models of value-based care, and what foundations are needed to facilitate this?	CHQ agree that delineation between ABF services and block funded services is becoming less clear as hospitals, health services and healthcare partners focus on delivering value and patient/family focused care including the provision of services 'closer to home'. These initiatives often reduce the frequency and volume of hospital attendance/admission. IHPA should consider how these innovations including non-hospital based activities could be recognised in an ABF environment to avoid confusion between funding streams and encourage hospitals to undertake initiatives they do not necessarily rely on 'volume' to drive funding. For example the creation of additional non admitted classifications could allow the counting of patients in specific programs that do not meet current ABF counting rules.
Section 12.5.1 Risk adjustment model	
Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?	Yes, CHQ support the development of an equitable risk adjusted model for Hospital Acquired Complications, however the following issues are recommended for consideration: The proposed Age groups including banding 0 – 4 years (and in particular the first few days of life) excludes the impact of the comorbidity (including congenital factors) and complexity of babies and children under one year where the model of care is 'treat at all costs'. For example the model could

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	include age in days under one year, neonatal care type or birth weight as risk factors. In Specialist Paediatric Hospitals Cardiac complications, Renal failure and gastrointestinal bleeds are, in the majority of cases, events closely associated with the underlying admission condition and are an in most cases an expected complication that is not present on admission. As the risk adjustment model does not adjust to 'zero', coding standards may need to be adjusted to reflect complications and or comorbidities that are not present on admission but are an expected part of the disease process i.e. Renal failure following admission for septic shock. The Charlson Comorbidity Index does not adequately reflect paediatric patient acuity and it is recommended that an expanded/ separate risk-adjusted comorbidity model for children should be considered to include conditions such as congenital disorders. For example the Derek Tai et al paper *Arch Pediatr Adolesc Med. 2006;160(3):293-299. doi:10.1001/archpedi.160.3.293* describes the approach undertaken to develop a Paediatric Comorbidity model in Ontario, Canada. The proposed proportional adjustment based on each individual patient's NWAU value and therefore associated AR-DRG assumes the HAC cost is dependent on the DRG, not the complication that has occurred. CHQ do not support this proposal and believe this is inequitable and penalises Hospitals providing Tertiary/ Quaternary services. For example, it would be difficult to explain to clinicians and hospital staff the apparent pressure injury cost difference in the example below: **1. Pressure injury** | | DRG | NWAU1718 | High Adjustment (1.0%) | Adjustment at NEP | Moderate Adjustment (6.9%) | Adjustment at NEP | Low Adjustment (13.8%) | Adjustment at NEP | |---|---|---|---|---|---|---|---|---| | Patient 1 | A06B TRACHEOSTMY/VENT>=96HRS, INTC | 337.19 | (3.37) | ($16,556) | (23.27) | ($114,238) | (46.53) | ($228,476) | | Patient 2 | D03Z SURGICAL REPR CLEFT LIP/PALATE | 2.43 | (0.02) | ($119) | (0.17) | ($823) | (0.34) | ($1,645) | CHQ believe a 'fixed' risk adjusted HAC adjustment is a fairer and more transparent means of reflecting the actual HAC Cost as currently adopted by Queensland Health for adverse events. The technical specifications paper is difficult to fully understand and does not allow readers to fully reconcile the model (A request to IHPA for further clarification and paediatric examples has been made 09/08/17). A fully functioning risk adjustment software grouping model should be made available to Hospital and Health Services to allow individual analysis, reconciliation and full assessment of local data.

Consultation Question	CHQ response
Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?	No comment, service not provided by CHQ.
Section 12.6.1 Policy context of pricing and funding models to reduce avoidable hospital readmissions	
What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?	CHQ would support the development of a risk adjusted model that identifies variance from the national mean rate as an instrument to reduce rates of avoidable admissions as per the Variable Life Adjusted Display (VLAD) model used by Queensland Health.
Section 12.6.3 Criteria for assessing pricing and funding options	
Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing and funding adjustments for avoidable hospital readmissions? Are there any other criteria that should be considered?	Yes, CHQ has no further suggestions for additional criteria.