NSW GOVERNMENT | Health

Mr James Downie
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Our ref H17/64407

Dear Mr Downie

NSW Submission on the Consultation Paper 2018-19

Thank you for the opportunity to comment on the *Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2018-19*. NSW is generally supportive of the approach taken by the IHPA.

A detailed NSW Health response is enclosed.

In support of the National Health Reform Agreement's principle of transparency, I endorse the publication of NSW Health's submission on the IHPA's website.

If you would like to discuss NSW Health's position, please contact Ms Jacqueline Ball, Executive Director, Government Relations on 9391 9469.

Yours sincerely

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23/8/17

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IHPA Consultation Paper
Pricing Framework for
Australian Public Hospital Services 2018-19

NSW Health Submission

This submission provides comment on the Consultation Paper prepared by the Independent Hospital Pricing Authority (IHPA) regarding the Pricing Framework for Australian Public Hospital Services 2018-19.

Chapter 4 Classifications used by IHPA to describe public hospital services

4.3 Australian Refined Diagnosis Related Groups classification

Consultation Question:
• What additional areas should IHPA consider in developing Version 10 of the Australian Refined Diagnosis Related Groups classification system?

NSW has been an active participant in the Diagnosis Related Technical Group and supports the IHPA's approach to review and unpack pricing related challenges for pregnancy complications, burns and major trauma, tracheostomy weaning and electro-convulsive therapy.

NSW would recommend the following areas be investigated for use in AR-DRG Version 10:

1. Obesity: should be considered a mandatory field within the coding standards as identified in the Emergency Department Costing Study. Obesity is known as a key cost driver and it is poorly recorded across jurisdictions.
2. Consultation Liaison: recognise consultation liaison within all admitted services as a secondary procedure.
3. DRGs for high cost and highly specialised procedures and technologies: The DRG for high cost technologies such as those with Nationally Funded Centres status (for example Islet Cell Transplantation) may not reflect the actual costs of providing the service, including the intensity of outpatient and multidisciplinary team clinics required to support the clinical services. In particular, NSW requests that the IHPA further investigate the delivery of Endovascular Clot Retrieval and the appropriateness for referring it for classification and coding development. NSW has seen a steady increase in the number of procedures delivered since 2014 and projections indicate this trend is likely to continue through 2021. The development of a classification for this service would enable jurisdictions to identify the procedure and effectively plan and cost the service.

Recommendations of additional areas for IHPA to consider in the development of V10 of the AR-DRG classification system:

- Consider obesity as a mandatory field within the coding standards.
- Recognise consultation liaison as a secondary procedure.
- Review the DRGs for high cost and highly specialised procedures and technologies.

Consultation Questions:

- Do you support the phasing out of older versions of the Australian Refined Diagnosis Related Groups classification system?
- What time frame would be sufficient for the health care sector to transition to the more recent versions of the classification?

NSW supports the IHPA's proposal to phase out older versions of the Australian Refined Diagnosis Related Groups (AR-DRGs). This will support national consistency and facilitate more feasible comparisons of data across years.

NSW is of the view that a minimum of a 12 month notice period would be sufficient for jurisdictions and the broader health sector to upgrade to a more recent version of the AR-DRG (including Version 7, Version 8 and Version 9) classification and to sufficiently map between older and newer versions.

IHPA's multiple uses of the classification systems, including describing, counting, costing and pricing services, requires strong data and clear communication to users to understand the specific context in which the classification is applied. A balance is needed between evolving the classification systems to keep pace with emerging models of care and the implementation of new technology, and the need for the IHPA to collect evidence of the impacts of implementation. Moving too quickly between DRG versions impacts on system manager's capacity to project and plan activity. NSW recommends that 12 months of data collection is undertaken prior to the introduction of any new version of a classification to ensure that new versions meet the classification system's needs.

Recommendations in relation to phasing out of older AR-DRG Versions:

- Phase out older versions of the AR-DRG classification.
- Provide a 12 month notice period prior to phasing out any Version.

4.4 Australian National Subacute and Non-Acute Patent Classification

NSW is supportive of the IHPA's decision to continue to use AN-SNAP Version 4 to price subacute services for NEP18. NSW seeks further clarification from the IHPA regarding what level of activity constitutes 'sufficient' for the purposes of pricing paediatric palliative care services using the AN-SNAP classification for 2018-19. NSW recommends that the IHPA continue to use care type per diem to price subacute paediatric services until NEP19 when costed paediatric activity is collected through the National Hospital Cost Data Collection.

IHPA has signalled its intention to develop AN-SNAP V5 and NSW seeks further information from the IHPA regarding their plan for implementation and evaluation, including an evaluation of Version 4. Classification development should be considered on a needs basis.

NSW also recommends that the IHPA consider same day terminal phase palliative care; in-reach rehabilitation, paediatric assessment tools for rehabilitation when developing V5.

Recommendations relating to the AN-SNAP Classification:

- Use AN-SNAP Version 4 to price subacute services for NEP18.
- Provide further clarification of 'sufficient' activity for the purposes of pricing paediatric palliative care services.
- Continue to use care type per diem to price paediatric services until NEP19.
- Clarify intention to implement Version 5, and any intention to evaluate Version 4.
- Assess NSW's recommended inclusions in developing Version 5.

4.5 Tier 2 Non-Admitted Service Classification

NSW recommends that the IHPA prioritise and escalate the development of the Non-Admitted Care Classification. NSW supports the promotion of patient-centred care and reiterates the importance of a classification system that is flexible enough to adapt to emerging models of care and the transition of care from an acute admitted setting to a non-admitted setting.

Recommendation relating to the Tier 2 Non-Admitted Service Classification:

- Prioritise and escalate development of the Non-Admitted Care Classification.

4.5.1 Multidisciplinary care conferences where a patient is not present

Consultation Question:

- Do you support the proposal to shadow price non-admitted multi-disciplinary case conferences where the patient is not present for NEP18?

NSW provides in-principle support for shadow pricing of multi-disciplinary case conferences where a patient is not present but notes that 2018-19 will be the first year of activity data collection for these services. As such NSW supports a shadow price for NEP 19 (after a full year of data collection).

NSW also recommends that MDCCs should be recognised as a modality of care provided by Tier 2 speciality clinics, classified by clinical specialty and provider characteristics for the clinic type.

Recommendations on shadow pricing MDCCs:

- Determine shadow price for NEP19 following one full year of data collection.
- Recognise MDCCs as a modality of care provided by Tier 2 clinics.

4.5.2 Home Ventilation

Consultation Question:

- Do you support investigation of the creation of multiple classes in the classification for home ventilation?

NSW supports the IHPA's investigation into the creation of multiple classes in the classification for home ventilation to ensure that any proposed changes are warranted and identify any cost differential.

NSW has undertaken its own analysis of the cost variation between overnight and continuous ventilation, and has found that there is a cost differential between the actual cost of this service compared to the Tier 2 NWAU for the clinic. NSW is prepared to share this information with the IHPA to assist in their investigation.

Recommendations on creating multiple classes for home ventilation:

- Investigate the creation of multiple classes for home ventilation.
- IHPA to work with NSW to analyse NSW findings relating to cost differentials between actual costs of home ventilation services and the Tier 2 price weight for the clinic.

4.6 Emergency Care Classification

In 2015-16, NSW moved to using Relative Value Units (RVUs) for emergency care, resulting in significant cost profile changes across Urgency Related Groups (URGs) classification. NSW notes that this change is cost neutral overall; however there is a risk that there could be unintended consequences in specific URGs as the IHPA applies its stability policy in developing NEP18. The IHPA will need to work with NSW to appropriately incorporate this state-wide change into a national pricing model.

Recommendation relating to the emergency care classification:

- Investigate the impacts of implementing RVUs for emergency care.

4.7 Teaching, Training and Research

NSW seeks further clarification from the IHPA on how jurisdictional compliance for meeting Teaching, Training and Research (TTR) data submission to the National Best Endeavours Data Set will be reported. Given that it may take jurisdictions up to five years to meet the requirements, NSW considers that reporting on the TTR data set should be considered best endeavours only and excluded from compliance reporting.

Recommendation relating to teaching, training and research:

- Clarify data compliance rules to ensure that TTR data submissions are acknowledged as best endeavours and excluded from compliance reporting.

4.8 Australian Mental Health Care Classification

Consultation Question:

- What other issues should be considered in the development of Version 2 of the Australian Mental Health Care Classification?

NSW is of the view that a longer stabilisation period is required for Version 1 of the AMHCC to ensure that clinical momentum is upheld.

At the same time, NSW supports the ongoing development of the AMHCC Version 2 and identifies additional factors to the items outlined in the Consultation Paper, including:

- Better pricing patients with significantly higher lengths of stay or facilities with a skewed casemix
- Principal diagnosis should be considered alongside clinical complexity and comorbidity
- Patient/client living arrangements and other social factors
- Culturally and Linguistically Diverse backgrounds
- Further refine how child and adolescent patients are identified and described
- Assessment of the impact of thresholds for high and moderate classes within the Health of the Nation Outcome Scale
- Further work to support the inter-rater reliability study.
- Feasibility of using mental health involuntary days in weighting of inpatient episodes.
- Using the highest HoNOS score not the first HoNOS score to drive the phase class. For example, Older Person Mental Health clients are frequently expected to deteriorate over time and require increasing levels of support. Similarly, inpatients will frequently be admitted before the acute onset of their mental illness has peaked in order to mitigate the risk of harm.

Recommendations on Version 2 of the AMHCC:

- Further develop Version 2 of the AMHCC whilst Version 1 stabilises and clinical buy-in builds.
- Consider additional issues raised by NSW for IHPA's consideration in developing Version 2.

Chapter 5 Data Collection

5.1.1 Australian Hospital Patient Costing Standards

NSW provides in-principle support for the development of these standards and agrees with the IHPA that the Standards should result in greater consistency and improved comparability for future rounds of the collection. NSW asks that the IHPA consider undertaking an impact assessment prior to national implementation of the standards to enable jurisdictions to fully understand the changes to cost profiles and backcasting implications. An independent financial review plan would also be beneficial to meet this need.

Recommendation relating to the Australian Hospital Patient Costing Standards:

- Undertake an impact assessment of the Standards to enable jurisdictions to fully prepare for implementation.

Chapter 6 Setting the National Efficient Price for activity based funded public hospitals

6.1.1 Pricing mental health services

Consultation Question:

- Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price for 2018-19?

NSW is of the view that no further technical improvements should be considered until the Australian Mental Health Care Classification Version 1 is priced and an evaluation is undertaken. NSW notes that the IHPA is not pricing mental health care in NEP18 and has not established a suitable proxy for mental health phase of care.

Recommendation on pricing mental health services:

- Defer further review of technical improvements to pricing for mental health services until the AMHCC is priced and evaluated.

6.2 Adjustments to the National Efficient Price

NSW supports the IHPA reviewing the patient remoteness adjustment for NEP18, and investigating the potential adjustments for home ventilation, as identified in the Consultation Paper. NSW also recommends the IHPA considers the following adjustments for NEP18.

Delirium and Dementia in Older Patients

In sub-acute care delirium and dementia is acknowledged in a GEM-type patient but not across other types of patients. There is acknowledgement that low cognitive FIM scores in some rehabilitation type classes impact on NWAU assignment. Further review into the price weights where dementia and delirium is either a principal or additional diagnosis is needed to determine whether the pricing model adequately accounts for the higher costs associated with these patients across all care types.

Obesity/Bariatric Adjustment

This patient characteristic is a significant cost driver in ED and acute admitted settings. NSW recommends that a review be undertaken to collect data on the difference in cost for these patients across jurisdictions. These patients typically use more expensive beds, chairs, wheelchairs, trollies, hoists and lifters that other patients do not use, and usually have more complications and comorbidities.

Peer Groups

NSW is of the view that the current national ABF model does not appropriately accommodate for small rural ABF hospitals, who consistently report a cost ratio > 1. NSW seeks the IHPA's consideration to separate peer groups for pricing purposes to allow for unavoidable costs experienced by rural and remote hospitals, noting that provider-based adjustments already exist in the NEP for paediatric and ICU hospitals.

NSW has implemented a Recognised Structural Cost component into the NSW funding model to correct these factors that are not reflected in the national model.

Transport Adjustments

In 2015-16, NSW implemented a cost allocation change whereby all transport costs are allocated at the patient level. NSW recommends that the IHPA analyse NSW's costing results to assess the impact of this allocation of transport costs to determine whether it may lead to the recognition of a legitimate and unavoidable cost for rural and remote facilities.

Telehealth

NSW recommends that the IHPA consider the development of telehealth as a modality of care, covered across all care-type settings. Telehealth services delivered in the emergency department and admitted settings (particularly in ICUs) could be captured through the URG/UDG and clinical coding process. This method of care promotes an innovative and flexible treatment approach and should be encouraged by clinicians as an alternative method of care.

Private Patient Service Adjustment

NSW raises for the IHPA's consideration the appropriateness of the private patient service adjustment accounting for both prosthesis costs and medical costs. Prostheses costs are incurred by the hospitals and reimbursed by health insurance funds whilst medical costs are paid to the clinician. In the interests of improved precision in the pricing model, NSW recommends that the IHPA splits the private patient service adjustment into two components recognising the different characteristics for these prosthesis and medical costs.

Recommendation on adjustments to the NEP:

- Support reviewing remoteness and considering home ventilation
- Consider including delirium/dementia, obesity, peer groups, transport adjustments and telehealth in NEP18.
- Split the private patient service adjustment into two components – prosthesis and medical

6.3 Stability of the national pricing model

Consultation Questions:

- What are the priority areas for IHPA to consider when evaluating adjustments to NEP18?
- What patient-based factors would provide the basis for these or other adjustments? Please provide supporting evidence, where available.

NSW remains concerned with the continuous volatility of the indexation applied to the NEP.

The IHPA should amend its indexation methodology to include prospective changes advised by jurisdictions that will have an impact on the base cost of providing health services. This may include new award increases or increases in the cost of consumables above the normal CPI. The current methodology does not allow for these changes to be reflected in the indexation rate for a number of years.

Separately, from 2015-16 onwards NSW has changed its costing allocation methods for teaching training and research. This has impacted on the cost attributed to ABF services in NSW. These changes will have a material impact on the indexation calculation and NSW is willing to work with IHPA on the most appropriate way to incorporate these changes into the indexation and back-casting approaches.

Recommendation on the stability of the pricing model:

- Amend the indexation methodology to include prospective changes.

National Disability Insurance Scheme

Through previous Pricing Frameworks the IHPA has acknowledged that as the National Disability Insurance Scheme (NDIS) is progressively implemented across the country there will likely be impacts on the national pricing model. By extension, there will also likely be impacts on payments through the National Health Funding Pool.

NSW notes that by 1 July 2018 the NDIS will be substantially implemented in NSW, South Australia and the Australian Capital Territory whilst other jurisdictions will be continuing to transition. It is timely for the IHPA to re-visit the impacts of the NDIS introduction to the counting, costing and pricing approaches within the national pricing model.

NSW notes that the IHPA previously investigated specific diagnosis codes for a specific cohort of patients with a disability as part of developing NEP16, and found that there was no cost differential for these patients. In the current environment, NSW is investigating a data collection mechanism to identify multiple cohorts of patients with disabilities, and proposes to work with the IHPA to determine relevant timeframes to provide this data for incorporation into the development of NEP18 or NEP19.

On the payment side, the NDIS introduction represents a significant shift in the mix of funders for the health services provided to NDIS clients compared to the mix of funders

previously. Careful analysis will be required to inform how payments through the NHFP are calculated and whether adjustments are required to reflect base and growth funding.

Given the material counting, costing, pricing and funding impacts across the national public hospital system from the NDIS introduction, NSW recommends that the IHPA, in conjunction with the Administrator of the National Health Funding Pool, undertake an impact assessment to inform current and subsequent national pricing and payment decisions.

Recommendation on the National Disability Insurance Scheme:

- IHPA and the Administrator of the National Health Funding Pool jointly work with jurisdictions to undertake a costing, pricing and funding impact assessment from the NDIS implementation.

Chapter 7 Setting the National Efficient Price for private patients in public hospitals

7.2.1 Phasing out the private patient correction factor

NSW supports the IHPA's decision to retain the correction factor for NEP18 given that private patient costs are not consistently captured across public hospitals. NSW is of the view that the Australian Hospital Patient Costing Standards (AHPCS) Version 4 should be fully implemented into the National Hospital Cost Data Collection prior to the phasing out of the correction factor.

NSW notes that there is an ongoing challenge for the system to comply with the AHPCS Visiting Medical Officer data requirements.

Recommendation relating to the private patient correction factor:

- Retain the correction factor until the Australian Hospital Patient Costing Standards Version 4 is fully implemented.

Chapter 9 Setting the National Efficient Cost

9.1.1 Transferring services from ABF hospitals to block funded hospitals

Consultation Questions:

- Should IHPA ensure that there is no financial penalty due to the transfer of public hospital services from ABF hospitals to block funded hospitals?
- If so, how should this be carried out?

NSW is of the view that any transfer of public hospital services from ABF to block funding should be cost neutral.

A block funded approach may be more appropriate for services that experience significant variation across jurisdictions, including the way the service is provided, classified, counted and costed. In instances where a single national price weight is not representative of the actual cost of a service, a block funded approach would be preferred.

Further, a block funded approach would enable baselines of service delivery to be determined for any new service introduced, and enable natural stability to be achieved prior to consideration for ABF.

NSW recognises the limitation of the national model for small hospitals and has implemented an alternative model from 1 July 2017. This model has been developed to resolve the challenges faced by small hospitals to deliver services under the ABF model. The current national approach does not include incentives to better utilise potential idle capacity in nearby small hospitals, creating further diseconomies of scale. The NSW small hospitals funding model takes into consideration fixed and variable costs for small hospitals in delivering in-scope services.

Recommendations on block funding:

- Transfer of services from ABF to block funding should be cost neutral.
- Consider using a block funding approach for any new classification being introduced or for services that experience significant variance across jurisdictions.
- Review the appropriateness of the NSW small hospitals ABF model for national adoption.

9.2 Teaching, Training and Research

NSW notes that the IHPA have undertaken significant work to develop the National Public Hospital Establishment Database (NPHED) so that it accurately identifies direct and indirect costs. NSW recommends that the IHPA consider using the NPHED to determine costs for TTR. To do this, the IHPA could reference the NPHED in conjunction with seeking jurisdictional advice relating to TTR expenditure to guide the NEC Determination.

Recommendation relating to teaching, training and research:

- Use the NPHED in conjunction with jurisdictional advice for determining TTR expenditure in the NEC Determination.

9.3.1 Residential mental health care services

Consultation Question:

- Do you support the IHPA's proposal to continue to block fund residential mental health care in future years?

NSW supports the proposal to continue to block fund residential mental health services. NSW notes that there are national inconsistencies in the breadth of services reported as residential mental health services, varying from short stay step-up/step-down services to very long stay facilities. A consistent approach needs to be developed prior to the consideration of moving residential mental health services into the ABF model.

At present there is not a consistent, national classification or pricing model for long stay mental health service admissions. It affects three specialised psychiatric services within

NSW (Orange Health Service, Cumberland Hospital and Macquarie Hospital) all of which have a high proportion of long stay, chronic mental health patients who reflect a limited AR-DRG range and therefore, a skewed case mix.

NSW has significant concerns regarding the flow of funds for sub-acute mental health episodes of care that do not both start and finish within the same financial year. NSW supports introducing the 200 day rule as a solution.

Recommendations on residential mental health care services:

- Continue to block fund residential mental health care services.
- Develop a nationally consistent approach to reporting of these services.
- Consider re-introducing the 200 day rule.

Chapter 10 Bundled pricing for maternity care

Consultation Questions:

- Do you support the proposed bundled pricing model for maternity care?
- Do you agree with IHPA's assessment of the preconditions to bundled pricing?
- Do you support investigation of whether the Individual Healthcare Identified or another unique patient identifier could be included in IHPA's national data sets?

NSW provides in-principle support for bundled pricing for maternity care.

NSW agrees with the IHPA's assessment of the preconditions to bundled pricing and recommends that the IHPA prioritise the precondition of 'clear benefits to patients' prior to implementing a bundled pricing approach for maternity care.

NSW also raises the following comments for IHPA's consideration relating to bundled pricing for maternity care:

- **Time lag of data collection used to determine the bundle**: there is a risk that using data up to three years old may not reflect current models of care.
- **Appropriate incentives for clinicians**: the IHPA should ensure that the approach provides opportunity to incentivise clinicians to adopt a bundled service.
- **Alignment with principles of National Health Reform Agreement**: the application of the principles of MBS contributions to non-admitted services may not be appropriate under clauses A6 and A7 of the NHRA. Any element of a bundled service that attracts an MBS payment may be considered out-of-scope under the Agreement, even though the service may be appropriate to include in designing a bundled price that accurately reflects the cycle of care.
- **Interaction with local and jurisdictional policies**: the IHPA should take into consideration the impact of back-casting requirements and the implication of the stability policy.
- **Comprehensive assessment of implementation**: The IHPA should consider all operational risks associated with the implementation of a bundled pricing approach.

NSW supports an investigation into whether the Individual Healthcare Identifier or another unique patient identifier could be included in IHPA's national data sets. There is a need to be

able to identify and understand a patient's journey, while highlighting and supporting a collaborative approach to treatment.

Whilst there are significant challenges in implementing a national bundled pricing approach, NSW supports the IHPA's work to thoroughly investigate a bundled pricing model to support the feasibility of effective bundled pricing in the near term. Until such time that a national bundled pricing model is appropriate, the IHPA should support jurisdictions to implement local bundling approaches. For example, in NSW General Practitioner / Midwifery shared models of care are commonplace, improving access to care and reducing overall length of stay.

Recommendations on bundled pricing for maternity services:

- Prioritise the precondition of 'benefit to patients' in developing a bundled pricing approach.
- Support jurisdictions to implement innovative funding models at a local level whilst a national approach is developed.

Chapter 11 Innovative Funding Models

Consultation Questions:

- 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?

NSW considers that a strategic review should be undertaken of the national ABF system five years on from the initial National Efficient Price and National Efficient Cost Determinations. Somewhat qualitative in nature, the purpose of a strategic review would be to understand what all parties have learnt; where the national model has served parties well and where the model has not worked well; identify ongoing limitations of the national model and help to inform a future model that builds on the success of the national approach and address major or fundamental limitations.

A strategic review should be completed prior to the IHPA introducing major advancements in innovative funding models. A strategic review may identify issues that are within the scope of IHPA's functions as well as issues that require broader consideration by governments.

NSW has been developing innovative models of care and is challenged by the inflexibility of the current national funding model. The current classification system does not support NSW in the delivery of programs such as the NSW Integrated Care strategy, Leading Better Value Care, nor the Mental Health Social Investment strategy. NSW recognises such clinical programs as an ongoing health strategic priority and requires classifications, costing and funding practices to support this in a timely manner.

In considering innovative funding models, the following foundations should be considered:

- Responsiveness/timeliness
- Integration across the health sector

- Transparency – ability to disaggregate and re-aggregate components of the care cycle to support innovation and new ways of working
- Clinician engagement – leveraging knowledge/expertise, encouraging buy-in to drive cultural and clinician/provider change
- Evidence-based

Currently under the IHPA's service event definition care undertaken by non-clinical support workers is not considered in-scope, even though the care is delivered by a hospital substitution program. NSW asks that the IHPA review the flexibility of the current non-admitted classification and adjust the model to recognise innovative non-admitted emerging model of care as in-scope NEP activity.

Recommendations on innovative funding models:

- Work with jurisdictions to undertake a strategic review of the national pricing model
- Work with jurisdictions to develop foundations for innovative funding models
- Review the flexibility of the current non-admitted classification to recognise innovative models of care as in-scope NEP activity.

Chapter 12 Pricing and funding for safety and quality

NSW agrees in principle with the implementation of pricing and funding approaches for safety and quality in health care. NSW is of the view that safety and quality largely remains a system manager issue and has invested significantly in improving safety and quality in the NSW health system through an incentivising approach implemented in purchasing arrangements. NSW recommends that the IHPA consider a suite of pricing levers that includes incentives as well as the current penalties as a more nuanced approach to better incentivise clinical behaviour change and safety and quality improvements for patients.

Recommendation in relation to pricing and funding for safety and quality:

- Consider approaches to the pricing model that incentivise clinicians to improve safety and quality in health care delivery.

12.4 Sentinel Events

In accordance with the National Health Reform Agreement Addendum, from 1 July 2017, any episode of care that results in a sentinel event will not receive Commonwealth funding, effectively assigning that event a payment NWAU of zero.

The Addendum further outlines that states and territories are to apply a digital flag to any episode that includes a sentinel event, and are to provide the IHPA with this information as part of the normal data submission process (Clause I64) or at a later time after a sentinel event has been confirmed. NSW seeks confirmation from the IHPA that prospective data submissions will be used to evaluate whether a discount is applied, as opposed to retrospective data collections such as the use of 2014-15 cost data referenced in the Consultation Paper. Furthermore, NSW does not support the algorithmic identification of sentinel events as this is contrary to the Addendum Agreement.

Recommendation in relation to sentinel events:

- Apply discount for sentinel events that occur after 1 July 2017, as intended under the National Health Reform Agreement Addendum, based on a jurisdiction's digital flag in the data.

12.5 Hospital Acquired Complications

Consultation Questions:

- Do you support the proposed risk adjustment model for HACs? Are there other factors that IHPA should assess for inclusion in the model?
- Do you agree that HACs third and fourth degree perineal lacerations during delivery and neonatal birth trauma be excluded from any funding adjustment?

NSW supports the proposed risk adjustment model for HACs as it takes into consideration multiple risk factors. NSW notes however that there appears to be some bias in the current model due to the high levels of HAC percentages within most complex DRGs, which disproportionately affects tertiary hospitals. NSW recommends that the IHPA review the model for this bias.

NSW also recommends for the IHPA's consideration that the risk adjustment model account for more preventability factors as opposed to individual patient profiles and the outcomes of the care provided. For example, if a patient suffers from Deep Vein Thrombosis whilst undergoing treatment despite the delivery of best practice care to avoid this complication, at what point is the condition considered unavoidable. Further clarification is needed to identify whether best practice care was followed and the associated penalty should reflect the quality of care provided. Furthermore, the model should reward recently improved behaviour, which may not be evident in historical data collections.

NSW notes that the IHPA intends to shadow this pricing approach. NSW seeks further clarification from the IHPA as to how they will operationalise the results of the shadow year implementation having regard to the requirement to report back to AHMAC.

NSW supports the IHPA's approach to exclude third and fourth degree perineal lacerations during delivery and neonatal birth trauma from any funding adjustment due to the lack of unreliable data.

Recommendations on HAC model:

- Investigate bias of high level HAC percentages associated with most complex DRGs.
- Identify preventability factors as well as risk factors.
- Clarify shadow pricing intent and possible operationalisation of the model.
- Exclude third and fourth degree perineal lacerations during surgery.

12.6 Avoidable Readmissions

Consultation Question:

- What pricing and funding models should be considered by IHPA for avoidable hospital readmissions?

NSW supports the development of a robust approach to reduce avoidable readmissions in public hospitals, to improve patient outcomes and reduce avoidable demand on public hospital services. It will be important that the conditions included in any approach, and reasoning behind their inclusion, is evidence-based, and that those conditions are sufficiently responsive to clinical management.

A pricing and funding model for avoidable hospital readmissions must be responsive to the specific clinical characteristics of each condition being assessed for inclusion. Substantial clinical engagement will be essential to gauge the realistic scope for change in clinical management practices that would be required to reduce readmissions rates for a condition, and then reflect this advice through a pricing or funding mechanism. The work currently underway by the ACSQHC to develop a list of clinical conditions considered to be avoidable readmissions, and to develop suitable condition-specific timeframes, is expected to inform these decisions.

Any model to price avoidable readmissions needs to account for social and economic patient factors as well as health co-morbidities. This includes homelessness and chronic addiction as often the health condition is not the primary factor in assessing the actual health risk of a patient.

NSW recommends for the IHPA's consideration the isolation of the value of the readmission penalty so that the funds may be moved from the acute setting where the avoidable readmissions are occurring and into programs that can be developed to improve patient outcomes and support keeping patients out of hospital.

NSW notes that a pricing approach may not be the best way to address readmissions for all conditions. Scenarios where this might not be the right approach could include where a clinical condition is considered as an avoidable readmission, but clinical consultation on a condition-specific timeframe is unclear, or the scope for change in clinical management may vary greatly amongst facilities. Evidence to support these decisions is essential for meaningful change.

It would also be desirable that any approach for avoidable readmissions aligns with other safety and quality reforms. A consistent strategic aim for all reforms is important, and will aid in the development, implementation, monitoring and reporting of these approaches for evaluation and performance purposes.