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RACP Submission to Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20

July 2018

Introduction

The Royal Australasian College of Physicians (RACP) welcomes this opportunity to provide feedback to the Independent Hospital Pricing Authority (IHPA) regarding its Consultation Paper on the Pricing Framework for Australian Public Hospital Services 2019-20 ('Consultation Paper').

The submission will focus on the following issues identified in the Consultation Paper:

- Further areas for development of the Australian National Subacute and Non-Acute Patient (AN-SNAP) classification
- Development of the Australian Teaching and Training Classification
- Consideration of alternative National Efficient Cost methodologies
- Additional areas for technical improvements to the National Efficient Price model
- Funding approaches for avoidable hospital readmissions.

Areas of development for AN-SNAP Version 5

The development of AN-SNAP with respect to the Geriatric Evaluation and Management (GEM) reconditioning codes requires further clarification and guidance from IHPA. To avoid these codes being used interchangeably with Rehabilitation codes, which in the experience of our Geriatric Medicine Fellows still occurs[1], we recommend more specific direction and definitions regarding how patients should be classified.

The RACP notes that IHPA is currently reviewing the measure of patient cognitive impairment in the GEM branch of the classification. We recommend that in its review IHPA investigate the use of alternatives to the FIM (Functional Independence Measure) Cognitive measure. In the view of our Fellows in Geriatric Medicine, the following measures are superior to the FIM:

- MoCA (Montreal Cognitive Assessment),
- RUDAS (Rowland Universal Assessment Dementia Scale)
- MMSE (Mini-Mental State Examination)
- AMTS (Abbreviated Mental Test Score).

The FIM Cognitive measure is generally not regarded among our Geriatric Medicine Fellows as the most appropriate measure of function in GEM patients.[2]

The RACP notes that IHPA is also Investigating the relationship between the psychogeriatric care type and the Australian Mental Health Care Classification. We have received feedback from a Palliative Medicine Fellow that there are benefits for retaining the psychogeriatric care type within the AN-SNAP stream rather than merging it with the Australian Mental Health Care Classification for the following reasons:

- The older patient with behavioural and cognitive symptoms related to delirium and dementia primarily under the care of specialist geriatricians and other physicians rather than psychiatrists should be delineated.
- The psychogeriatric care type patient may have very different lengths of stay and assessment requirements and may require different kinds of hospital and post hospital support resources (e.g. they are unlikely to be managed in a mental health ward or by mental health clinicians and staff).

We also recommend avoiding where possible any substantial annual changes in the price weights for AN-SNAP classes (e.g. spinal classes) given the increasing frequency of introduction of new versions.

Development of the Australian Teaching and Training Classification

The RACP notes the important work being undertaken by IHPA to develop the first version of the Australian Teaching and Training Classification (ATTC) to enhance transparency and efficiency of funding of teaching and training related activities in public hospitals. We look forward to further updates on this important piece of work.

[1] Personal communication from the Chair of the Clinical Committee of the Australian and New Zealand Society for Geriatric Medicine.
[2] Personal communication from the Chair of the Clinical Committee of the Australian and New Zealand Society for Geriatric Medicine.

Like all activities, the time expended in hospitals on teaching and training has an opportunity cost because of the additional time required for trainees and their supervisors to develop the clinical skills of the next generation of physicians. It is therefore important that clinical teaching and training in public hospitals is delivered in conjunction with patient care even if that means the hospital taking more time for each patient episode than might be the case in a non-teaching hospital setting.

Ultimately time invested in the future human capital of physicians yields positive spill-over benefits in terms of enhanced quality and safety of healthcare (and avoided future costs associated with potentially preventable complications). For these reasons, teaching and training should be regarded as a core business of the healthcare system.[3] We further note that to ensure the appropriate nuances are captured in the development of these classifications, we encourage IHPA to continue to consult broadly both with an appropriate range of teaching hospitals and medical colleges and also with trainees themselves.

Therefore, we recommend that remuneration for hospital time expended on teaching and training should not just be aimed at allowing hospitals to recover their costs but also to incentivise the healthcare system to invest sustainably in an activity that has ongoing long-term benefits to the general population. This may require a level of funding that is more generous than simple cost reimbursement. Provision must also be made in the development of the ATTC to align it with overall national medical workforce priorities.

Consideration of alternative National Efficient Cost methodologies

The RACP agrees that further consideration should be given to alternative methodologies for calculating the efficient cost of block funded hospitals which are hospitals with activity levels too low to be suitable for funding on an activity basis, such as small rural hospitals. As noted in the Consultation Paper, the current approach is to 'block' fund' such hospitals based on these volume groups and other factors but one problem with a 'pure' block fund approach is that funding will not increase commensurate with increases in hospital activity when these changes in activity are between volume groups. To ensure greater equity in the distribution of funding within this group of predominantly small rural hospitals we support attempts to introduce greater flexibility in funding through a 'fixed plus variable' model where each hospital receives a fixed funding amount (determined using a number of variables) and a variable ABF style amount.

Additional areas for technical improvement to the National Efficient Price model

The RACP recommends that IHPA investigate the implications of technological and device based advances in clinical assessment and diagnostic care for the pricing model used to determine the National Efficient Price. There should also be a continued focus on ensuring that recent advances enabling better face to face interaction between clinicians (whether with or without the patient present) such as new device technologies and telehealth are taken into account and appropriately compensated for, as this will have implications for recognition and incentivisation of multi-disciplinary case management. More generally, clinicians should not be undercompensated just because they undertake patient-centred activities which keep their patients out of hospital but which still require a commitment of time and use of their expertise such as case conferencing.

Funding approaches for avoidable hospital readmissions

Definitional issues

To design the best approach for reducing avoidable hospital readmissions, it is important to have an appropriate working definition of avoidable readmissions. Based on the findings cited in the Consultation Paper (the majority of avoidable readmissions occurred when patients presented to either the same hospital or a hospital within the same Local Hospital Network) the RACP agrees with the proposal that the appropriate geographical scope for avoidable readmissions should be readmissions within the same Local Hospital Network.

[3] AMA 2012 Funding models for medical teaching, training and research: Objectives and principles

We note that condition-specific readmission intervals have been recommended by the Australian Commission on Safety and Quality in Health Care and that these range from two days for readmissions for several different types of infection to 90 days (for venous thromboembolism and infection associated with devices, implants and grafts). We favour the development of condition-specific readmission intervals as appropriate though we understand that an overall all-causes readmissions interval is also required for publication and reporting purposes. To add to this evidence base, we note recent research from the US suggests that at least for three common conditions (acute myocardial infarction, heart failure, and pneumonia), after day 7 post-discharge, hospital readmissions are mainly a result of community and household-level factors rather than factors within the control of the hospital.[4]

Another issue is whether readmissions (however defined based on specific intervals, scope of included and excluded services or geographical scope) should be measured within or across financial years. We agree with IHPA that extending the measurement of readmissions across financial years would introduce new complexity by potentially requiring retrospective funding adjustments to hospitals across financial years. Therefore, we favour keeping measurements within financial years.

Funding models

The Consultation Paper distinguishes between 'pricing' based approaches which remove all costs attributable to avoidable readmissions from the National Efficient Price and 'funding' based approaches which adjust compensation for hospital episodes based on whether the episode is classified as an avoidable readmission. The Consultation Paper notes that the pricing based approach received very limited support in previous submissions because of its lack of transparency and lack of targeted incentives since the reduction in NEP affects all hospital episodes of all hospitals regardless of performance (unless combined with hospital level funding adjustments). For this reason, the Consultation Paper only listed funding options for consideration. The RACP agrees with this reason for restricting consideration to funding options. We do not think that a pricing level approach to treating avoidable readmissions is sufficiently well targeted and runs the risk of penalising all hospitals regardless of performance.

The options listed in the Consultation Paper consist of two 'episode level' funding approaches (Options 1 and 2) and one 'hospital level' funding approach (Option 3). We note that the approach that IHPA has adopted for treatment of hospital acquired complications (HACs) is an **episode level** funding. approach whereby funding is reduced for any episode of admitted acute care where a HAC occurs from 1 July 2018, commensurate with the incremental cost of the HAC (i.e. the additional cost of providing hospital care attributable to the HAC). This reduction is subject to an adjustment based on the risk of that patient acquiring a HAC, to account for patient specific factors beyond the control of the hospital which it should not be penalised for.

However, despite the use of an episode level funding approach for HACs for addressing avoidable hospital readmissions, the RACP recommends the use of Option 3 i.e. the **hospital level** funding approach. This approach involves applying funding adjustments only to those avoidable hospital readmissions that represent an 'excess' level of readmissions. We favour Option 3 for the following reasons:

- Unlike HACs, preventability for more commonly occurring readmissions is better characterised as being on a scale of probability rather than being a 'black and white' question. There are few readmissions that can be determined through administratively derived intelligence that can be absolutely described as 'preventable'. Therefore, a more nuanced approach is required than to simply deny a hospital payment for the entire (Option 1) or part of (Option 2) the cost of an episode defined as an avoidable readmission. We therefore commend the approach of Option 3 which is to withhold payment from a hospital for a proportion of index avoidable hospital readmissions that represent an 'excess' level of readmissions.
- Option 3 has the additional advantage that the results of the measurements of excess readmission rates across Local Hospital Networks can also be made available to all hospitals, thus creating an additional 'audit and feedback' with peer comparison (or in this case, comparison between Local Hospital Networks). Under this approach, given that the statistics would need to be collected anyway it might also be helpful to disseminate to each hospital their own performance on excess readmissions within the LHN. This form of audit and feedback (i.e. with peer comparison or with relative

[4] Chin DL, Bang H, Manickam RN, Romano PS. Rethinking Thirty-Day Hospital Readmissions: Shorter Intervals Might Be Better Indicators Of Quality Of Care. Health affairs (Project Hope). 2016;35(10):1867-1875.

performance statistics) has been found in recent studies as providing enhanced incentives to change clinical behaviour[5].

- We note that Option 3 most closely resembles the approach recently adopted in the US under the Hospital Readmissions Reduction Program which has already been found to have a significant effect on the inpatient readmissions for pneumonia, acute myocardial infarction and heart failure.[6]

We note that Option 3 will require further careful consideration and research on what the appropriate benchmarks should be – for instance what should constitute an acceptable versus an 'excess' level of readmissions and whether this benchmark should be set at the national, State, LHN or even hospital specific levels. We also note that because this is a population based approach it does not account for individual patient variability and the demographic characteristics of the 'population basin' served by a hospital being assessed under the benchmark. Therefore risk-based adjustments will need to be made to take these characteristics into account to ensure that hospitals are not being penalised for factors beyond its control. More generally. funding incentives (or to be more specific, disincentives) for avoidable readmissions ultimately need to be underpinned by appropriate resourcing and support for better integrated care. For instance, to keep older, frailer, more dependent patients at home, interdisciplinary community teams are often required which will likely carry additional costs comparative to single clinician interventions We understand that some (though not all) of these considerations may be outside IHPA's remit as they relate to reforming our currently highly fragmented (both in terms of funding and allocation of responsibilities) healthcare system. Nonetheless, it is important to ensure that these holistic considerations are borne in mind in designing and implementing funding incentives.

[5] Meeker D, Linder JA, Fox CR, et al. Effect of Behavioral Interventions on Inappropriate Antibiotic Prescribing Among Primary Care Practices: A Randomized Clinical Trial. JAMA. 2016 Feb 9;315(6):562-70. doi: 10.1001/jama.2016.0275.
[6] Lu N, Huang KC, Johnson JA. Reducing excess readmissions: promising effect of hospital readmissions reduction program in US hospitals. Int J Qual Health Care. 2016;28(1):53-8