IHPA Consultation Paper
Pricing Framework for
Australian Public Hospital Services 2020-21

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 2020-21.

2 The Pricing Guidelines

Consultation Question:
Question 1: Are the Pricing Guidelines still relevant in providing evidence on IHPA's role in pricing Australian public hospital services?

NSW considers the Pricing Guidelines important in providing a consistent approach to IHPA's operations.

IHPA should consider the impact of incorporating capitation funding on pre-eminence of ABF in the System Design Guideline, and how this will merge with the overarching guideline of "Efficiency". The response by IHPA to provide appropriate funding approaches is delayed and the alternatives being funded are non-ABF based.

IHPA should note the ongoing challenge to meet the "Fostering Clinical Innovation" Guideline. Across LHDs there is support for guidelines to foster innovation, new technologies and best practice. However, frontline services are concerned that updates to coding, costing studies and subsequent price determinations are behind by at least 2-3 years, and behind the current innovation or new technology. Furthermore, new technologies are not always immediately efficient, and the need to scale up over a couple of years means that a lead service bears the brunt of costs not covered by the efficient price in this start-up period. This can be a disincentive to innovate despite best practice.

IHPA should not restrict considerations of the impact of technology to the inpatient setting. NSW maintains that IHPA should further investigate ways of introducing flexibility into the pricing model that supports innovation and technology in the outpatient setting.

NSW does not support removal of the aggregated NAP NBEDS as this will increase the administrative burden on services that are currently not staffed to collect this level of data, or where the administrative overhead takes more time than the clinical interaction is brief which contradicts the "Administrative Ease" guideline.

NSW recommends further discussion on the guideline "Timely, quality care". A focus on adjustors that extend the definition of quality care beyond absence of adverse events would be beneficial for IHPA's work.

Consultation Question:
Question 2: Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support value in hospital and health services?

NSW supports this inclusion. The inclusion of "Promoting Value" in the guidelines aligns with the NSW Leading Better Value Care (LBVC) strategy, however the statement could be revised to ensure that patient outcomes are a priority.

IHPA should consider changing the statement to 'Pricing should support innovative and alternative funding solutions that deliver efficient, high quality care, with patient outcomes at the forefront of treatment.'

To further value-based outcome approaches, IHPA should consult more broadly at a clinical discipline level. This may mean broadening the membership of the IHPA CAG.

NSW encourages IHPA to define "value" so that is it clear what they are promoting, and what is considered low value. In defining this concept, IHPA also need to determine the impact of the definition of value on the funding methodology and the evidence needed to support it. As a national dataset on PROMs/PREMs does not exist, IHPA need to consider alternative approaches to use in the development of an inclusive pricing model.

Recommendations:

- Include discussion on definitions and mechanisms employed to ensure "Timely quality care"
- Consider the impact of incorporating capitation funding on the pre-eminence of ABF in the System Design Guideline
- Note and discuss the ongoing challenge to meet the "Fostering Clinical Innovation" guideline and current restrictions
- Reconsider the removal of the aggregated NAP NBEDS
- Consider revising the new guideline to *"Pricing should support innovative and alternative funding solutions that deliver efficient, high quality care, with patient outcomes at the forefront of treatment*"

3 Scope of Public Hospital Services

No comments

4 Classifications Used to Describe and Price Public Hospital Services

4.1 Overview

No comments

4.2 Admitted acute care

Consultation Question:

Question 3: What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACT Twelfth Edition?

The Australian Coding Standards 12th edition should dedicate a detailed chapter to a broad range of examples and scenarios regarding COF 1 and COF 2 assignment rules to minimise triggering of 'false' HACs — that is, some conditions that arise in a hospital do not always equal a HAC. This would better ensure that the ACS and the ACSQHC have correlating views.

NSW recommends that IHPA establish an Acute Care Working Group consistent with other ABF streams so that strategic discussions can occur in relation to the classifications used for admitted patient care. For example, consultation could be undertaken to determine if there is support for embedding sub-acute and AMHCC classification systems (continuing to use their current data elements), driven by the care type, into a single grouping system. Inclusion of the required variables into ACHI procedure codes or Diagnosis codes (such as the impairment codes in sub-acute) could enable a single data collection to hold all the required data elements and variables to classify into the relevant stream. This would reduce the burden on the system for maintaining separate data collection

systems and methodologies and the documentation could continue to be recorded in the patient's medical record as is. Consideration would need to be given to impacts on clinical coding workforce and information systems. This will be especially important in preparation for the introduction of ICD-11.

Comments from NSW LHDs:

- The review may look beyond diagnosis as determinants of complexity and investigate more social and functional determinants of complexity
- IHPA should balance representation of complexity in coding with other priorities as new ACS002 standard limits representing complexity in some cases where there are significantly more resources provided to care for those patients. The risk of being unable to code the complexity due to ACS002 while still having the increased resource usage to manage the patient.
- IHPA should undertake consultation to determine if there is support for introduction of ICD codes for in-reach services such as mental health consultation liaison services.
- IHPA should provide national forums and other opportunities for consultation and education for Clinical Coding Professionals to understand new updated classifications and groupers, and impacts on clinical documentation.

The following are specific examples that NSW recommends IHPA review for improvements in DRG v11 and ICD-10:

- In accordance with the Fostering Clinical Innovation guideline, of particular relevance are the increasing use of bone marrow transplants (BMTs) in the non-admitted setting and differences between allogenic and autologous BMTs. IHPA should move to ensure that DRG v11 and ANACC v1 adequately capture the difference in complexity and current models of care, and variations in corresponding costs, as current classifications do not.
- CAR T-cell and other specific treatment programs within cancer services.
- Other high cost therapies, such as treatment of Cystic Fibrosis, spinal cord injuries and non-invasive ventilation.

Recommendations:

- For ACS 12th edition, dedicate a chapter with a broad range of examples or scenarios as outlined above
- Consider including or embedding sub-acute and AMHCC classification systems into a single grouping system
- Note the complexity of multipurpose classifications.

Consultation Question:

Question 4: Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?

NSW supports the review of the admitted acute care classification development process. NSW recommends that IHPA undertake consultation to determine if there is support for parallel development and release of both ICD and DRG classifications. Each new DRGs classification version could be based on new ICD/ACHI version.

IHPA should consider in the review how the AR-DRG can more closely align with other classifications for similar encounters. This can be done alongside the finalisation of the AECC and the development of the ANACC. For instance, where infusions can be given in ED or as a same day patient, or where scope can be done as either non-admitted or admitted care. A similar naming convention will allow

ease of comparison for the correct cohort of patients. The focus of change may be in other classifications as opposed to the AR-DRG classes but this should be reviewed and a considered approach taken.

ICD-11 has been developed conscious of the advanced technological environment into which it will be implemented, compared to the usage of ICD-10. Recognition and flexibility of the use of the classification in different environments and technological platforms should be a consideration.

Health systems are moving towards a more value based, rather than volume based, approach and are increasingly focused on the patient's input into their health service experience. These strategic directions should be acknowledged, and implementation and use of classifications should support that forward direction. This would also apply to other 'service category' classifications.

Comments from NSW LHDs:

- IHPA should ensure that Tier 2 price weights remain relevant while building ANACC as the build coincides with a period of moving admitted activity to non-admitted settings.

Recommendations:

- Enable parallel development and release of classifications
- Consider how the AR-DRG can more closely align with other classifications for similar encounters
- Consider development of ICD-10 codes to accurately reflect sub-acute and AMHCC care
- Consider flexibility of classifications in different environments and technological platforms
- Consider discussions on value based care in classification development

4.3 Subacute and non-acute care

NSW requests further information on any changes to the timeline for AN-SNAP v5.

4.4 Non-admitted care

NSW has provided a report on the formation of the new non-admitted classification alongside this submission.

4.5 Emergency care

4.5.1 Pricing for emergency care

Consultation Question:

Question 5: Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?

NSW does not envisage any impediments to pricing the AECC Version 1.0 in July 2020. Any significant change to classification systems should be shadow funded for one year. Jurisdictions and LHDs should be given the opportunity to review and evaluate their data in the new classification prior to funding allocation. An education campaign needs to be developed prior to full implementation and pricing. The education material needs to be appropriate for clinicians, clerical staff and managers alike.

IHPA should work with jurisdictions to ensure current IT systems have a readiness and capability to incorporate additional diagnosis at all sites.

NSW needs to complete testing on the AECC Grouper to ensure its algorithms are processing the data as expected.

NSW does not expect any barriers in Emergency Departments collecting ED principal diagnoses.

Recommendations:

- NSW supports the timeline proposed
- Allow for jurisdictional data evaluation using the new classification
- Develop an education campaign prior to implementation

4.6 Teaching, training and research

NSW supports determination of 2020-21 block funding amounts for teaching, training and research (TTR) activity based on state advice.

4.7 Mental health care

4.7.1 Refining mental health 'phase of care'

Refer to Question 6

4.7.2 Pricing of mental health care

Consultation Question:

Question 6: Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?

NSW supports the concept of pricing to AHMCC, however recent investigations suggest the classification is not yet robust enough for use.

The recent report issued on the clinical refinement of 'phase of care' offers a number of proposed changes to the phases. IHPA state that they "*will not be making significant changes to the Phase of Care model at this stage*". NSW requests that IHPA clarify what is considered to be a significant change as NSW considers the proposed changes in the report to be significant and could negatively impact the classification.

A significant number of respondents noted that there was difficulty in distinguishing between the five mental health phases of care. NSW requests IHPA provide the risk management plan to identify the steps IHPA will take to ensure the momentum within the current classification is not lost.

Significant data quality issues have been identified in the AMHCC admitted and non-admitted data sets. Issues include linking and the application of the concept of phase in non-admitted. Substantial work is required to understand the data and to implement changes to the classification to make the data more robust before pricing is considered. There is a risk that pricing based on current AMHCC data will be flawed. Pricing is premature at this point as NSW does not consider mental health data integrity to be adequate for the purpose.

To address the issues noted above, prior to pricing, and as supported in the phase of care, end user training and education for AMHCC is needed. This should be a high priority, along with improving the definitions of the existing phases. These priorities will assist in improving data integrity, enabling IHPA to develop appropriate price weights.

NSW requests that IHPA clarify pricing of both admitted and non-admitted mental health services is intended. This is not clear in the consultation paper.

IHPA should review the R23 data submission to determine whether it is more reliable as a data source than R22 for pricing AMHCC. The inconsistency of data for the first round of costing is likely to produce invalid price weights.

NSW further requests clarification on how the AMHCC will distinguish and fund services such as mental health ICUs, where the patient cohort has significantly increased costs compared to standard

inpatient care. HoNOS does not adequately distinguish these patients and therefore causes significant underfunding of these services (this is similar to ICUs in the acute hospital setting).

With specific regard to inpatient high-risk mental health services, IHPA should ensure that the following have been considered when evaluating adjustments:

Length of Stay: the majority of high-risk adult mental health patients have very long LOS, the average being in excess of two years.

Security: The security classifications for high-risk patients and facilities have major cost implications that are not currently taken into consideration in the pricing framework.

Gender: Acuity, co-morbidity and socio-psychological factors for high-risk female mental health patients.

Age: both emergence of mental illness and socio-psychological factors in adolescent mental health patients accessing inpatient mental health services.

Recommendations:

- NSW does not support implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020
- Advise on approach to address concerns with data quality
- Advise on education to be made available
- Provide a risk management plan regarding phase definitions

5 Setting the National Efficient Price for Activity Based Funded Public Hospitals

5.1 Technical improvements

NSW welcomes the completion of the Fundamental Review, however continues to have concerns with regard to the consultative process and statistical decisions undertaken. IHPA should consider the impact of interference with the pricing model as a result of underlying classification changes. The nature of the pricing model should be self-correcting without the need for adjustment year on year caused by changes in classification.

The pricing model was adjusted in move to DRG V8 and change to the underlying DCCL model. IHPA has implemented counteractive changes in DRG V10 (noting no updates in V9 DRGs) that will result in a reversal of the change implemented in V8.0. The pricing model adjustment previously enforced will now need to be reversed upon the implementation of DRG V10.

If the pricing model was not “adjusted” for the V7 to V8 change then no subsequent adjustment for future version changes would be required. However, now that the system has been “penalised via adjustment” then the expectation is that when the reverse results from V9 to V10 occur that a counteractive adjustment will also be required.

To maintain the integrity of the funding model, IHPA needs to ensure consistency and stability in the way they set the classification and the pricing model – either adjust the classification and allow the pricing model to self-correct, or adjust the pricing model and leave the underlying classification intact. Switching the methodology between years undermines and compromises the overall integrity of the model.

NSW supports a review of how the costs associated with benefits paid through the Commonwealth pharmaceutical programs are removed. NSW notes findings of the fundamental review which demonstrated notable flaws in the linking methodology.

NSW supports the ongoing use of the average cost.

"*Work to further account for association and interaction between adjustment categories, for example the interaction between remoteness and indigenous status*" should be further defined. NSW supports this statement noting the information in the fundamental review on this matter.

NSW agrees with "*Incorporating adjustments for patient age into each of the pricing models*". IHPA should also consider using age in the complexity splitting of the classification system rather than adjusters.

5.2 Adjustments to the National Efficient Price

Consultation Question:
Question 7: Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?

NSW recommends IHPA use the data in the NHCDC and further investigate this at the cost item and bucket level. Regional facilities are most likely to incur costs associated with ensuring access to services; transport costs and higher technology costs for delivery of appropriate care are inevitable. Whilst this is not possible to measure by the cohort of patients, the diseconomies of scale are measurable and where there is evidence of diseconomies of scale the pricing model should consider suitable adjustments which cover the unavoidable cost components. NSW have considered and recognised the concept within the NSW funding model.

NSW would value the opportunity to work with IHPA on costing of special care nurseries, interpreter costs, consultation liaison across all streams, and regional retrievals.

Recommendations:

- Investigate NHCDC data at the cost item and bucket level as outlined
- Consider for a for discussing the specific examples outlined above

5.3 Harmonising price weights across care settings

NSW supports harmonisation of price weights across care settings.

5.4 Setting the National Efficient Price for private patients in public hospitals

5.4.1 Costing private patients in public hospitals

No comments

5.4.2 Phasing out the private patient correction factor

Consultation Question:
Question 8: Is there any objection to IHPA phasing out the private patient correction factor for NEP20?

At this time, NSW supports a review of private patient adjustments but strongly recommends IHPA do not remove this adjustment.

NSW notes that consistency and standardisation of arrangements has yet to be achieved. For example, there remain significant differences in the allocation of costs to private patients for diagnostics. IHPA should provide a state by state assessment to acknowledge the differences in arrangements in place.

NSW is working towards implementing best endeavours for the 2018-19 NHCDC Submission. However, compliance with Business Rule 1.1A Medical expenses for public and private patients is subject to the availability of data held in SPAs.

Recommendations:

- NSW does not support IHPA phasing out the private patient correction factor for NEP20.

6 Data Collection

6.1 Overview

No comments

6.2 Phasing out aggregate non-admitted data reporting

NSW does not support phasing out aggregate non-admitted data reporting.

NSW notes privacy considerations for some vulnerable services such as violence and abuse. Further, there are existing challenges in collecting existing patient-level data where third party providers are involved.

NSW has expressed concerns through National Data Governance committees.

6.3 Access to public hospital data

Consultation Question:

Question 9: Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?

NSW refers IHPA to comments on this subject in the NSW Submission to the Consultation Paper on the Pricing Framework 2019-20. As agreed by all jurisdictions, access to the data in the National Benchmarking Portal is limited to those using health department IT systems.

NSW does not support the NBP becoming publicly available. NSW highlights the following additional concerns:

- There remain comparability issues across states and jurisdictions that need to be resolved before making the data public. For instance, the treatment of business unit services will have a significant impact on the ability of the users to compare across states for cost buckets (such as pathology).
- NSW Health will require IHPA to detail the specific safeguards and parameters it will use to protect patient or provider privacy.
- The data also requires a level of understanding that is unique to health and complex in nature. The tool requires a high level of technical skill and it would be easy for the filters to be incorrect and the data misrepresented. Public access to the NBP with HAC data without an understanding of complexity, rules and classification systems creates a high risk of misunderstanding and misuse. IHPA would need to provide training to the public on how to understand (including variations and limitations), use and interpret the data.
- There is a risk of commercial misuse if the data are broadened.
- Protection of patient data is vital and safeguards should be in place.

Recommendations:

- NSW does not support IHPA making the NBP publicly available.

6.4 Unique patient identifier

Consultation Question:
Question 10: What are the estimated costs of collecting the IHI in your state or territory?

Whilst in principal NSW supports the ability to reflect a complete patient's journey, NSW does not support the provision of the IHI at this stage. Currently, <80% of patients have a valid IHI in NSW. Ethics approval would be needed to allow NSW to release this data to IHPA, once we get to an acceptable level of patients with valid IHI numbers.

NSW Health believes it is not appropriate to provide costings in a public consultation paper.

NSW has many practical and technical issues to address to enable the provision of records with the IHI. Costing of work to determine the processes for and availability of the IHI has not been undertaken at this point.

Recommendations:

- NSW does not support the collection of the IHI at this stage, or the provision of costings in a public consultation paper.

Consultation Question:
Question 11: Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?

The paper is unclear on how the payments would be administered. NSW does not support funding adjustments associated with use of IHIs at this time, but is willing to continue discussions around the introduction of the IHI.

Provision of funds to support the incorporation of the IHI into local and state wide business and technical processes for its provision in nationally reported data sets may assist in raising this work on an already packed state wide ICT work program. However:

- NSW notes concerns with data quality. NSW notes that at this time, we cannot obtain a reliable IHI for approximately 20% of patients.
- NSW notes that more patient focused programs will have priority within the existing work program.
- Incentives would need to be a permanent increase in budget to accommodate staffing requirements to address increased data provision.
- NSW Health is still addressing privacy and technical concerns and issues with the capture, use and storage and subsequent provision of the IHI in nationally reported data sets.

Recommendations:

- NSW does not support the collection of IHI at this stage, incentive payments for provision of patient data with IHIs, or funding reductions for episode records without IHIs.

6.5 Patient reported outcome measures

Consultation Question:

- Question 12: What initiatives are currently underway to collect PROMs and how are they being collated?

In NSW PROMs and Patient Reported Experience measures (PREMs) are collected through a range of local initiatives and programs covering a wide variety of clinical contexts. NSW Health is now developing a strategic, more coordinated approach to patient reported measures (PRMs) to support the system-wide move to value based health care.

Value Based Health Care (VBHC) is a framework for organising health systems around the concept of value. In NSW, VBHC provides the opportunity to focus on what matters to patients to improve health outcomes, the experience of giving and receiving care along with the effectiveness and efficiency of care. The collection and collation of Patient Reported Outcome Measures (PROMs) is a vital part of VBHC

NSW originally implemented PRMs as a proof of concept (POC) in and component of the Integrated Care Strategy in 2015. A number of LHDs participated in the POC and the learning from this phase has been used to scale up the roll out.

NSW Health has finalised a PRMs framework that will guide our collection and use of PROMs. To improve consistency in collection and use of PROMs and PREMs, NSW Health is building an integrated electronic PRMs system and subsequent state wide data asset. This is a significant investment from both a technical and change management perspective.

From September 2019, the system will be trialled in thirteen clinical cohorts through the NSW Leading Better Value Care (LBVC) and Integrated Care programs, before expanding to include other priority cohorts. Over time it is envisioned that the system will support the routine collection of PRMs across all clinical cohorts to support real-time use by clinicians and patients, and service and system evaluation.

The IT system being built will also be able to be used in primary care settings. NSW Health is actively working with individual GPs and the Primary Health Networks to develop a primary care implementation plan including data governance processes.

PROMs data will be collated and used for a range of purposes including:

- to inform real time clinical practice
- compare across disease and cohort groups
- measure the effects of a disease of treatment
- compare benefits between different populations
- monitor changes over time, or influence policy/practice changes and planning and health service management
- measurement and evaluation of programs and services.

While PROMs data will be collated in a standalone data set they will be also integrated into other NSW Health datasets.

The IHPA paper makes reference to Clinical Quality Registries (CQR). NSW Health supports the concept of a registry in so far as it is "a mechanism to provide clinicians, patients and health system managers with *timely feedback* on clinical practice *against agreed indicators of quality that are benchmarked, risk-adjusted* and based on *reliable data*".

NSW Health however is not supportive of any initiative that will embed future reliance on a 'traditional' CQR model to achieve this desired outcome. NSW has taken advantage of the increasing

sophistication of data linkage and created a virtual clinical registry to support the LBVC program - the Registry of Outcomes, Value and Experience (ROVE). ROVE, initially focusses on the 13 LBVC clinical cohorts and links administrative datasets (e.g. admitted, ED, deaths, NWAU, costing data, SNAP, non-admitted etc.) clinical datasets (e.g. audit, EMR, waiting list) and PRMs (outcomes and experience data).

Consultation Question:
Question 13: Should a national PROMs collection be considered as part of national data sets?

NSW supports the goal of a national dataset however our experience and learning from the implementation and collection of this data outlines the challenges of reporting PROMs at scale.

A national PROMs collection would rely on the goodwill of patients, carers and families to complete the PROMs surveys. This would also represent a significant change for the community and will require investment in health literacy.

In order for PROMs information to provide a meaningful picture of the patient journey it must be collected across all care settings including primary care and private health care. Establishment of a national PROMs data collection will require a substantial investment of resources from the Commonwealth and jurisdictions to enable data collection and to educate and engage the clinical workforce on the interpretation and use of PROMs. The implementation of the survey within a primary care setting may also require incentive measures.

A national dataset would support activities that sit under the NHRA long-term reforms, in particular enhanced health data and paying for value and outcomes LTRs. As such consideration needs to be given to a national roll out of PROMs and expectations around time lines to embed in service delivery.

It will be important to ensure that any national work on PROMs builds on the foundational work undertaken by NSW and supports and aligns with the work undertaken in other jurisdictions. Given the significant collection burden on patients and clinicians, any national work should focus on a minimal viable dataset and consider alignment where consistency is not possible to avoid patients having to complete multiple question sets for different purposes.

In particular consideration would need to be given to the standardisation of questions nationally to ensure comparability and reliability of the dataset.

PROMs are often considered in the context of safety and quality. While these are important considerations, in NSW PROMs are part of value based health care noting that systems can be of high quality and not produce value.

NSW would like to flag caution on how the data would be used, particularly in the realms of pricing and funding. It is not clear how IHPA intends to use PROMs data in the design of funding arrangements for hospitals. Further clarification is required to enable stakeholders to evaluate the feasibility and appropriateness of using PROMs information in this way. It is also important to note that in NSW, funding reform is considered an enabler of VBHC, not the objective. Funding reforms should not occur until we are clear about the outcomes we wish to achieve for our patients and have trust in the systems and tools we uses to consistently measure this.

7 Treatment of other Commonwealth programs

No comments

8 Setting the National Efficient Cost

8.1 Overview

No comments

8.2 Consideration of alternative NEC methodologies

Consultation Question:
Question 14: Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20?

NSW supports in principle the inclusion of shadow pricing the 'fixed plus variable' model for NEC20.

9 Alternate Funding Models

9.1 Overview

No comments

9.2 Global horizon scan

Consultation Question:
Question 15: Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF framework?

NSW understands that IHPA are keen to explore alternative funding models that support innovation. Innovative funding approaches will be facilitated through the work planned under the NHRA Paying for Value and Outcomes Long Term Reform. The current ABF model acts as a barrier to innovation, restricting the flow of funding that underpins any proposed model of care that cannot be easily categorised or defined by activity. Many models that address fragmentation within the system require more flexible funding models.

NSW requests IHPA support more models akin to the Victorian Health Links Program. Without this enabler the system will be unable to experiment with new ways of delivering care and adapt to meet fiscal pressures and population demand.

NSW encourages the flexibility of alternative funding arrangements whilst keeping to the principals of ABF and ABM. Alternative funding arrangements need to be assessed on a number of levels:

- The time period needed for capitation funding whilst a change management and embedding period occur for a new or redesigned service
- The ability to strengthen alignment of primary care and secondary care (integrated care) via incentive payments for specific patient cohorts, as part of hospital avoidance strategies. Components of this model would include improving health literacy, empowering the patient and measuring patient compliance against their treatment plan.

There is a need for a broader pricing model that does not isolate individual stream activity from other activity (e.g. non admitted in isolation to acute). The streams have become an obstacle to innovative clinical programs of work.

NSW advises that all out of hospital services should be incentivised in the pricing model. Noting that the emphasis in the pricing model would need to adapt to focus on incentives for hospitals and community services (which may be non-ABF) rather than the patient for a period of time to enable establishment of services and support networks in the community and out of hospital settings.

Recommendations:

- Consider the factors raised regarding alternative funding arrangements
- Discuss how to overcome the obstacles to innovation caused by isolation of activity streams

Consultation Question:
Question 16: IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?

NSW supports the concept of bundled payments. However, in practice it is difficult to operationalise this due to data collection and linkage issues. Bundling has to be done in a manner that appropriately shares clinical and financial risk. Bundling should also consider incorporation of private patients and patients in a public/private partnership setting.

Whilst IHPA considers Bundling as a series of payments across a single procedural journey, it can also be seen as a way of funding multiple providers and/or facilities in a short journey, i.e. one admission covered over a number of facilities. These would be hub and spoke clinical models that are carried out across facilities or LHDs.

The single patient journey may also include differing levels of care intensity across encounters or across sites within one encounter, until the place of definitive care is reached (e.g. rural ED to a non-specialised metro hospital to a specialised metro hospital). The use of telehealth in a bundling scenario when used to enhance care into an ED or acute setting needs to be further investigated to ensure the administrative burden does not become the obstacle to gold standard care.

NSW is scaling a number of care initiatives for patient cohorts in NSW. These include those at risk of hospitalisation, those who visit an ED ten or more times in 12 months, residential aged care facility residents, vulnerable families and paediatric patients. The care pathways provided to these patients is broadly defined and it will be possible to determine the average cost of care for these patients. Therefore, bundled payments should also be considered for Integrated Care patients, even though they might not have specific or single clinical conditions.

A bundled payment structure is also likely to support collaborative commissioning. This will improve care in the community by identifying patient cohorts locally, ensuring a continuous care pathway through joint work between the PHN and LHDs and other care providers who may be commissioned to provide services.

NSW proposes the “shadow bundling’ throughout 2019-20 in preparation for future bundled payments. The following suggestions have also been provided by NSW LHDs for further discussion:

- Elective procedures where pre and post op care is fairly structured e.g. Lens procedures
- Hip/knee replacements

Recommendations:

- Consider how to appropriately share risk within a bundled payment mechanism
- Broaden the definition of bundled payment to consider the factors raised above
- Consider bundled payments for integrated care patients
- Consider bundled payments in a collaborative commissioning setting
- Consider shadow bundling as outlined

10 Pricing and Funding for Safety and Quality

10.1 Overview

No comments

10.2 Sentinel events

No comments

10.3 Hospital acquired complications

10.3.1 Approach to funding of HACs

Consultation Question:
Question 17: Is IHPA's funding approach to HACs improving safety and quality, for example through changing clinician behaviour and providing opportunities for effective benchmarking?

NSW notes that the IHPA funding approach to HACs is just one lever within a broader system purchasing and performance approach to health service safety and quality improvements. The inclusion of a HAC adjustment will have increased focus on safety and quality. However, it is important that HAC adjustments are clinically meaningful, risk adjusted and fair. All HAC adjustments should be clinically validated in order to maintain clinician engagement.

Changing clinician behaviour will depend on number of factors, including collecting and presenting data in a meaningful way, identifying underlying causes of variation and making changes that are co-designed with clinicians to reduce unwarranted variation and improve reliability. Changes at the clinician and team level are unlikely to be driven by financial measures but rather by providing accessible improvement support to frontline staff. Both qualitative and quantitative measures should be used when assessing changes in clinician behaviour.

NSW considers incentives for clinical staff to improve HAC performance to be more appropriate than a penalty approach. This would allow for additional investment needed in safety and quality programs and allow the goal of improved safety and efficiency to be achieved.

NSW considers benchmarking tools as very effective in influencing clinician behaviour. However, the current approach does not provide clinicians with real time data to observe the impact of the HAC on the patient or health system other than in the immediate time period while treating the complication. NSW has invested heavily in providing such data to clinicians, and incentive payments to allow for more of this work to continue would assist in providing real time insights to clinicians that will lead to improvements in care.

Recommendations:

- Analyse incidence of HACs at national, state and facility level to determine if change has occurred
- Further review definition of HACs to reduce incidence of false positives
- Consider further incentives to enable real time insights to clinicians
- Consult on definitions and governance regarding HAC adjustments to enable a clinically meaningful, risk adjusted and fair focus

10.4 Avoidable hospital readmissions

No comments

10.4.1 Funding Options

No comments

10.4.2 Approach to risk adjustment

No comments

10.4.3 Commercial readmissions software

Consultation Question:

Question 18: What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?

NSW reiterates the comments made in the 2019/20 Pricing Framework response in regard to avoidable hospital admissions. NSW proposed a fourth option for avoidable readmissions and looks forward to the analysis of this option alongside the other three options.

NSW does not support another punitive approach to safety and quality elements that reinforces funding options that only consider readmission within the same hospital.

Software configuration should consider variables other than primary diagnosis such as weather (including air quality), substance use, health professionals' opinions (including general practice, allied health and nursing), patients' health literacy, medications, patient level of compliance with medications and other treatments, socioeconomic status, living arrangements and social support networks.

Any system should incorporate elements that can improve medical record documentation, correct patient identification, reduce medication errors and falls in hospitals.

NSW notes that it can be very difficult to identify whether an admission is potentially avoidable. The timeframe in which a readmission could be considered avoidable will depend on the condition being treated. While readmissions within 28 days may be considered the standard definition, for other conditions, seven days would be more clinically relevant.

Identification of contextual factors is required. IHPA should consider patient characteristics such as socioeconomic status, CALD status, functional status, ASA classification (for patients assessed for surgery), diabetes status, cognitive status (not limited to dementia), pain assessment (acute and chronic), and clinical frailty when determining whether a hospital readmission is potentially avoidable. It is also important to determine whether the care given at an initial admission for the condition is considered complete or if the initial admission is part of a series of admissions for the full treatment of the condition.

Any software used to identify potentially avoidable hospital readmissions must be validated. Evidence should be provided regarding completed validation to demonstrate that the software measures avoidable events and that data collection is robust.

Recommendations:

- NSW does not support the proposed punitive approach to safety and quality elements
- Include contextual factors, including patient characteristics, condition and intention of treatment
- Consider the software configuration variables outlined
- Consider patient characteristics as outlined
- Ensure software validated and suitable for use in the Australian context