IHPA Consultation paper on the pricing framework for Australian public hospital service 2021-22

The Royal Melbourne Hospital, NorthWestern Mental Health Comments for Consultation Questions

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3 Impact of COVID-19
What changes have occurred to service delivery, activity levels and models of care as a result of COVID-19?
For mental health services: ▪ Telehealth has been a change in service delivery: less face-to-face contact with consumers; clinicians are conducting less community home as they normally would (with current COVID-19 PPE precautions); consumer groups are no longer being held; ▪ Additional services have be implemented to address surge requirements associated increase in demand from the community, provision of training and concierge services for the hotels and homeless. ▪ Additional service provision for the hotspots such as quarantine towers, NWMH Centralised Triage service for Department of Premier Cabinet to meet community acuity and demand. ▪ Mental health inpatient units are also experiencing high levels of acuity. Bed-stock in mental health inpatient units currently not meeting demand; increase in people presenting with suicidal ideation. Impacting 28 day re-admission rate. ▪ Increased activity: restrictive interventions, including physical/mechanical restraint and seclusion. ▪ Additional screening at every entry point into the service is a big resource requirement. ▪ Travel restrictions, mental health clinicians working from home. ▪ Only urgent ECTs were conducted/scheduled. ▪ MHT – the tribunal are not holding their hearings in person and not seeing consumers in person, resulting in increased couriering of documents and reduced face-to-face time. ▪ Service demand has increased in acuity and intensity levels; including the increase in family violence ▪ An increase in the number of new consumers not seen before by mental services
How will these changes affect the costs of these services in the short and long term?
Mental health: extra hours for clinical staff, difficult to cost increased administrative burden on clinical, administrative and health information management staff; workforce challenges.
What aspects of the national pricing model will IHPA need to consider adapting to reflect changes in service delivery and models of care?
4 The Pricing Guidelines
Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?
Does the change to the public-private neutrality pricing guideline accurately reflect the intent of the Addendum?
6 Classifications used to describe and price public hospital services
6.1 Admitted acute care
What should be included in online education for new editions of ICD-10-AM/ACHI/ACS?
Coding of psychosocial issues for mental health admissions that are impacting care and length of stay. Ie homelessness
How should AR-DRG education be delivered and what should it include?
What improvements to the content and format of the electronic code lists could be made to enhance their utility?
Is there support to replace the hard copies of the AR-DRG Definitions Manual and ICD-10-AM/ACHI/ACS with electronic versions?
Yes, it would be useful to have electronic version, however it would still be useful to continue to publish the hard copy versions.
Are there other suggestions for approaches or measures to assess impact and readiness of ICD-11 for use in the classifications used in admitted care, or more widely?
Assess impact and readiness from the following perspectives: workforce readiness, resources, education and training, Australian clinical coding standards and rules for areas other than admitted care.

Review current use and application of ICD-10, identify any gaps and areas for improvement, and recognise areas to bridge on the transition to ICD-11.

6.3 Non-admitted care

Are there any other factors that should be considered for the addition of pain management and exercise physiology classes in the clinic nurse specialist/allied health led services of classes in the Tier 2 Non-Admitted Services Classification?

How would activity that falls under these proposed new classes previously have been classified?

6.4 Emergency care

What has been the impact on emergency department data since IHPA commenced shadow pricing using the AECC Version 1.0?

Are there any barriers to implementing pricing using the AECC Version 1.0 for emergency departments for NEP21?

6.5 Mental health care

How can IHPA further support development of pricing for community mental health services using AMHCC Version 1.0 to transition to shadow pricing?

Activity Based Funding for community mental health must consider: the quality and integrity of data, diagnosis codes, outcome measure inter-rater reliability, lack of clinical coding workforce in the community, and the fact that there is not an existing classification directly applicable to community mental health consumers. There is also a need to reduce duplication and administrative burden, on both clinical and administrative staff, where possible.

Community contacts

- Currently there is not a clear inclusion of what Victorian public mental health is currently collecting, classified as contact type D unreportable contacts; unreportable contacts are not well-accounted for in AMHCC v1.0.

Diagnosis

- Standardisation and consistency required for clinical coding, regular audits for quality assurance, consistent and applicable standards, improve the classification so that it also aligns with DSM-5.
- Allow for provisional diagnoses; review and update the appropriateness and applicability of the clinical coding classification model for community mental health coding.
- Victoria is working on a funding model that includes diagnosis in its classification and as a measure of complexity.
- We acknowledge the complexity of a mental health diagnosis, as this is not as clear-cut as a diagnosis confirmed by a test result, however this should not discourage factoring in of diagnosis as a contributor to a consumer's case complexity and care needs.

Phase of Care

- High integrity data is required with high inter-rater reliability. The PoC instrument must be further enhanced and refined prior to utilisation as a basis for pricing community mental health, prior to rollout across the Commonwealth, before shadow-funding. This can ensure consistent measures of consumers with similar mental health care needs and more accurately inform the development of pricing for mental health community.
- Age and complexity of PoC as well as other outcome measures should be included as factors in the funding and pricing model.
- Victoria has not yet commenced collecting PoC, with further delays of education and rollout due to COVID-19. This is a fairly large jurisdiction, from which information collected will greatly inform future development and refinement of the AMHCC.
- Also to consider inclusion of consumer and clinician based outcome measures.

Workforce

- Imperative that a trained workforce capture and code diagnosis and intervention codes; Health information managers have not been employed to code community episodes.
- Investment in HIM positions to code episodes and manage the data integrity

This is with the purpose of working towards development of a classification that accurately and comprehensively captures the complexity of our consumers at all points across their episode of care.

Are there any impediments to pricing admitted mental health care using AMHCC Version 1.0 for NEP21?

Diagnosis is not included in AMHCC v1.0; recommendation to include diagnosis as a classification factor. Diagnostic data provides a more complete picture of the complexity of consumers and their needs.

Victoria is currently reporting Focus of Care; data from Victoria would be of use and value in developing pricing. The mapping between PoC & FoC is not one-to-one. Phase of care rollout is yet to commence in Victoria. There is also a need to implement this consistently, along with high inter-rater reliability across Australia.
7 Setting the national efficient price for activity based funded public hospitals
7.2 Adjustments to the national efficient price
Do you support the adjustment IHPA has proposed for NEP21?
What evidence can be provided to support any additional adjustments that IHPA should consider for NEP21?
7.3 Harmonising price weights across care settings
Are there any obstacles to implementing the proposed harmonisation of prices for dialysis and chemotherapy for NEP21?
Are there other clinical areas where introducing price harmonisation should be considered?
7.4 Setting the national efficient price for private patients in public hospitals
Is there any objection to IHPA phasing out the private patient correction factor for NEP21?
10 Setting the national efficient cost
10.2 The 'fixed-plus-variable' model
Are there refinements to the ‘fixed-plus-variable’ model that IHPA should consider?
11 Alternate funding models
11.5 Individual Healthcare Identifier
What comments do stakeholders have regarding the innovative funding models being considered by IHPA?
What innovative funding models are states and territories intending to trial through bilateral agreements under the Addendum?
Are there other factors that IHPA should consider in its analysis to determine which patient cohorts or ADRGs are amenable to certain funding models?
What other strategic areas should IHPA consider in developing a framework for future funding models?
Apart from the IHI, what other critical success factors are required to support the implementation of innovative funding models?
12 Pricing and funding for safety and quality
12.4 Avoidable hospital readmissions
Do you support IHPA’s proposed pricing model for avoidable hospital readmissions, under funding option one at a jurisdiction scope level?
Are there any refinements to the risk adjustment model and risk factors that IHPA should consider?
What additional aspects does IHPA need to consider when implementing a funding adjustment for avoidable hospital readmissions?

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Consultation: NWMH HIM team across region