



**Submission to the Independent Hospital Pricing Authority on the  
Stakeholder Consultation Paper on the Development of the  
Australian Non-Admitted Care Classification (ANACC)**

**April 2018**

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## 1 Introduction

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission in response to the Independent Hospital Pricing Authority Stakeholder Consultation Paper on the Development of the Australian Non-Admitted Care Classification (ANACC).

AHHA is Australia's national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

AHHA supports moving the health system towards a patient centred, outcomes focussed and value based system. Essential elements of these principals are the coordination of care across healthcare settings, patient data (both service and outcomes related) being both compatible and portable between healthcare providers and a move away from episodic volume based healthcare.

The responses to the consultation questions below are based on comments provided by AHHA members operating in both primary healthcare settings and in public hospital settings.

### **1. Should the new classification for non-admitted care support the delivery of integrated care between health care settings? If yes, how?**

Yes — the new classification for non-admitted care should support the delivery of integrated care between health care settings.

With the move to integrated care being coordinated by Primary Health Networks and Local Health Networks, it will be important to be able to fund patient outcomes using classification systems and other tools that are closely aligned. It is appropriate that the ANACC classification system being developed is compatible with the development of primary healthcare datasets using the same terminology to describe the same conditions.

A pricing mechanism that accommodates the move to emerging bundled payment models, such as the *Health Care Homes* trial and the Victorian *HealthLinks: Chronic Care* program, would enable these models to better focus on the continuum of care across healthcare settings and over the course of a patient's care journey. Rather than focusing on episodic care, the pricing mechanism should accommodate patient treatment modes and transitions in care such as in-home monitoring, telehealth, the handover of care to a patient's primary healthcare provider(s) and the coordinated treatment of patients with multiple morbidities.

This could be accomplished through designated classes of integrated care, price weight adjustments for patients with recent admissions/presentations or inclusion of care coordination activities (where there may be no client contact) within the definition of a service event (or any future unit of count). Examples could include activity performed by the "key worker" under such a model of care or communication between health care providers when managing patients in integrated models of care. These types of care coordination activities form a major part of non-admitted care for paediatric patients, especially those with chronic or congenital conditions, and needs to be recognised and funded through the new classification system.

From the context of effective chronic diseases and population health management, the classification system and dataset must support care collaboration and coordination between health care settings. To achieve this, it is essential that development of the classification system and the underlying data elements is preceded by thorough whole-of-system collaborative care data flow analysis. The analysis should lead to mapping of the patient journey and care pathway across sectors, the touch points or intersection between care providers/sectors, the data flows required to support effective coordinated care planning and information sharing to support effective continuity of care. The classification and underlying data to support and measure outcomes of patient-centred collaborative care can be identified and then validated.

The new classification should also consider the impact of the setting of the service provision to support contemporary models of care and across various settings, such as hospital provided care compared to community provided care. The current remote adjustment rate only applies to the suburb of the patient not the location of the provider. A community setting is not always available in some rural areas and potentially there are patients whose postcode does not qualify for the adjustment hence these services are missing out. Services provided in the hospital can be more costly due to factors driven by its demand and location. Therefore, incorporating the setting in the weight determination or using an adjustment rate is integral to reflect the true cost of the service.

## **2. Should the new classification for non-admitted care services account for and adapt to newer models of care and technology? If yes, how?**

Yes — the ANACC should account for and adapt to newer models of care and technology.

This could be difficult to achieve through a standard classification and pricing model based on the National Hospital Cost Data Collection. One alternative is to use a hybrid approach where newer models of care or technology can be funded based on unit costing studies of a best practice treatment pathways rather than through an ANACC class.

An iterative process for development of the classification may provide the opportunity to move from activity funding towards a broader focus on outcomes. Where possible, the classification should also have regard to a population health planning approach where primary and tertiary health care providers work together to identify and address factors that affect a person's health. If the top levels of the classification system are focused on desirable outcomes for the patient, then the more detailed levels of 'how' could be amended over time without having to change the overarching structure of the system.

Technology enabled emerging and innovative models of care will generate and require additional data that current care models have not anticipated. These technology enabled care models have the potential to drive evidence- and value- based intervention, resulting in improved health outcomes. This is especially important in the context of population and patient risk stratifications and mobile health technology enabled individualised care and facilitation of home-based self-care and management. While conducting the whole-of-system collaborative care data flow analysis and mapping, the exercise should also include technology enabled emerging/innovative care and consumer self-care models.

**3. As the type of care delivered in admitted, non-admitted and primary care are challenged, how can the future ANACC system account for these changes?**

An essential feature of the ANACC is that it should not be an impediment to integrated care, in addition to being responsive to evolving models of care and the adoption of new technologies.

The ANACC should include adjustments for integrated care initiatives where additional services are moved into non-admitted (or other provider) settings. This is to ensure that there is no funding disincentive for facilities to pursue innovative models of care which may be beneficial to patients or represent a more efficient use of hospital resources. For example, if a same day admission may result in a higher NWAU allocation than a non-admitted service event, facilities may then elect to continue treating these patients in an admitted setting or risk a lower level of funding. There should therefore be a consolidated approach for the care type as the patient outcome is the same with the only difference being how the care is delivered.

Patient-centred collaborative care, specialisation of knowledge and services and shifting care boundaries across disciplines and care sectors, enabled by innovative applications of technologies, will impact care models over time. The classification system and underlying data elements will need to proactively evolve in-step with these changes.

**4. The classification principles have been designed to guide and support the development of the future classification, do you agree with these and/or are there other principles that should be considered in developing ANACC?**

The classification principles identified to guide and support the development of the ANACC are appropriate. However, the number of classification principles listed necessarily involves a compromise when developing a classification system. It would be unrealistic for a classification system to cover all principles, and it would be beneficial for health networks to understand what principles IHPA are prioritising and what compromises are being explicitly made.

The “simple and transparent” principle identifies a transparent and understandable process for assigning cases to classes. It is important to note that there needs to be a robust methodology on top of the process defining a set of rules, methods, tests activities, deliverables and processes. It might be useful to consider a technical principle to assist with the alignment of terminology and classification systems across non-admitted and primary care datasets. The Deeble Institute for Health Policy Research published an Issue Brief that considers the reliability and comparability of data obtained from general practice electronic health records.<sup>1</sup>

**5. Should IHPA continue to use service event as the ANACC unit of count? If yes, do you agree with the proposed revised definition of a service event? How could it be improved?**

Service event should continue to be used as the unit of count in developing and refining the ANACC. This is to ensure easier adoption and no loss in the granularity of data. The revised definition of a service event should also include multidisciplinary case conferences and self-delivered services without a healthcare provider.

The service event definition could be further extended to cover other resource intensive clinical activities which are beneficial to the patient but where the patient is not present eg time consuming

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<sup>1</sup> Gordon J, Miller G and Britt H. 2016. Reality Check - Reliable National Data from General Practice Electronic Health Records. Deeble Institute Issues Brief No. 18 (can be accessed [here](#)).

administration such as a pharmacist applying to the Therapeutic Goods Administration for certain medicines under the Special Access Scheme, liaising with schools, FACs, care navigation and other services etc.

**6. Should an episode be considered as a unit of count in the new ANACC? If not for all conditions, then for which specific conditions?**

An episode is a better unit of count for ANACC, where the episode serves as a higher level aggregation of service events. This may also be particularly relevant for those conditions managed predominately outside of the hospital setting and as integrated care becomes more embedded in the health system. An episode unit of count could be applied for all conditions, but perhaps different inlier thresholds (in terms of the duration of an episode or the number of service events that make up an episode) could be set for each condition or ANACC class in a similar manner to the inlier length of stay thresholds for each DRG in the admitted setting.

**7. Non-admitted patients often present with multiple comorbidities, and may be treated under a chronic disease management model. Should the future ANACC system have a separate path for classifying chronic disease patients?**

THE ANACC should have a separate path for classifying chronic disease patients. The care model and pathway of patients with chronic and multi-comorbidities are different from those with episodic non-admitted encounters of an acute/short term nature – these cases require a separate classification system that is based on continuity and collaborative care. Consideration should also be given to extending this approach to include conditions which may result in long term or permanent disability eg developmental delay in paediatric patients or congenital conditions requiring ongoing management.

The types of conditions that can be considered relevant comorbidities for chronic disease patients also differs greatly for paediatric patients. For example, the Charlson Comorbidity Index that is commonly used includes conditions such as dementia, COPD and liver diseases which may not be as relevant for paediatric patients compared to say patients aged 40 and over. Comorbidities more relevant to paediatrics (eg developmental delay, epilepsy and cerebral palsy) need to be separately considered and included in the classification system.

Patients with multiple chronic conditions may have episodic non-admitted encounters from time to time that are un-related to their underlying chronic conditions such as a fracture from falling off a bicycle. Episodes unrelated to their multimorbidity should be captured separate to their ongoing chronic care.

**8. What implementation timeframe is required for jurisdictions to transition to a patient-based non-admitted care classification system?**

The required implementation timetable will depend largely on the data requirements of the ANACC. The introduction of additional reporting requirements such as diagnosis-type variables are likely to require changes to IT systems, as well as clinical staff education and training.

Implementing a clinical based system into a hospital is a crucial process. Hence it is necessary to establish a realistic timeframe. However, it is possible that it might be possible to stage the implementation as follows:

First 6 months:

- Get support from executives
- Proposals and current system review
- Implementation and provisioning

From 6 to 9 months:

- Appoint a project team and define roles and responsibilities
- Establish workflows
- Technical infrastructure build to capture and report/audit new data requirements

From 9 to 18 months:

- Finalise infrastructure build
- Test of reports and audits
- User acceptance training
- User education and training
- Change management strategies to encourage full adoption

From 18 to 36 months:

- Iterations of feedback from clinical teams regarding technical infrastructure and data requirements of the new classification system
- Analysis of costing and activity results under the new classification system to determine the usefulness of the new system and to inform pricing.

International experiences and benchmarking in implementing/transitioning to new coding/classification systems (eg from ICD-9 to ICD-10) indicates a time frame of three years, which includes technology/system evaluation, testing and changes, user education, change in business processes and implementation evaluation. The changes and complexity associated with implementing the proposed classification system and underlying data elements is likely to exceed those for transitioning from ICD-9 to ICD-10 (ie greater than 3 years in addition to the time required for the classification and underlying data set testing and validations).

The implementation timeframe should also include time for identifying and rectifying perverse incentives that were not anticipated.

## **9. What considerations should be made in relation to including a diagnosis-type variable in the future ANACC system?**

It is noted that some activity in the non-admitted setting captured for ABF purposes is currently completed by administration staff rather than clinicians (through scheduling systems). Any classification system which is driven by diagnosis-type variables may shift the burden of activity capture from administration staff to clinicians. While clinicians may already be recording diagnosis information in medical records, capturing diagnosis-type variables in the manner described in ANACC (without a dedicated coding workforce) would require significant change management during implementation. Clinical systems must also be upgraded to allow for this data capture in a relatively simple way to minimise clinician burden and increase the likelihood of complete data capture.

It would be useful to include diagnosis information in the ANACC system along with other patient social-determinants of health (including geocoding), procedure/intervention, outcome and provider profile data to support meaningful analytics and knowledge generation.

Clinically the concept of “diagnosis type” is commonly considered to include concepts such as primary diagnosis, secondary diagnosis, provisional/primary diagnosis and differential/working diagnosis (Reference: Canadian Institute of Health Informatics). It appears that the consultation paper treats “diagnosis type” as synonymous with MDC categorisation eg paraplegia, quadriplegia, other spinal cord condition (Appendix A, p.34).

A strategic agreement should be reached regarding a common and consistent use of diagnostic terminology across ANACC and primary healthcare minimum data sets.

**10. Should presenting problem be used as the diagnosis type variable? If yes, do you agree with the proposed definition of ‘presenting problem’?**

Presenting problem is an appropriate diagnosis type variable in a non-admitted setting. The reason for encounter, limited to request for a service variables, may also add value in explaining the costs of non-admitted activity without an excessive administrative burden.

However, the concept of “presenting problem” can also be used synonymously with terms such as “chief complaint” or “presenting complaint”. The problem a patient presents with may not be established as the diagnosis. For example, a patient may present with a generic symptom of a cough, fever, chest pain, headache or abdominal pain, while the eventual diagnosis may differ from these symptoms.

**11. What are your views on the proposed list of initial presenting problem/diagnosis-type and intervention-type groups presented at Appendix A? What refinements should be considered?**

The broad categorisation of diagnosis and intervention type variables based on MDC is reasonable based on the assumption that clinicians are likely to be required to familiarise themselves with only MDC. However, for clinical staff (eg allied health providers) that may provide services across multiple health care clinics the list of diagnosis and intervention variables may be too extensive, and hence impractical. Further consultations with clinicians would be supported to refine the list of presenting problems.

An additional consideration is that these codes do not indicate severity and at times conflate clinical concepts. For example “dementia and other chronic disturbance of cerebellar function” includes two clinically different concepts and “other disorder of the digestive system” includes seven different conditions. This limits their utility to support accurate, condition specific predictive analytics. Clinical coding systems such as SNOMED-CT AU could be considered as an alternative.

Similarly, “dental extractions and restorations” have been itemised as separate from “general dentistry”. These would normally be considered an integral component of general dental care. It could also be argued that “orthodontics, prosthodontics and periodontics” crosses the divide between “general” and “specialist” dental care.

**12. Do you agree with the list of complexity variables presented in Section 5.3? What other variables should be considered for the new ANACC system?**

The complexity variables presented in Section 5.3 are generally agreed to subject to the comments that follow. When using age as a complexity variable, the distinction between paediatrics and adults is not necessarily reflective of the differences in resource usage within a paediatric facility. More granular age groups would enable the identification of differences in resource requirements within paediatrics in developing the ANACC. For example, using an age group of 0–14, or even 0–4, would



likely be insufficient as the models of care for infants would be very different to older children and teenagers resulting in different resource usage.

Furthermore, in assessing comorbidities, the current approach of using the Charlson Index as the primary measure of comorbidity burden is not as relevant in paediatrics due to the list of conditions considered in the original study which focused entirely on adult populations. Alternative comorbidity indexes such as those proposed by Tai et al (2006)<sup>2</sup> are more applicable for a paediatric population.

Consideration could also be given to capturing broader sociodemographic variables such as gender, ethnicity, education, income and geolocation as these variables impact on a person's health, are modifiers of health care need and add complexity to patient management. Consideration could also be given to separating out the complexity variables related to the patient from the service related complexity variables.

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<sup>2</sup> Tai D, Dick P and To T. 2006. Development of Pediatric Comorbidity Prediction Model. Archives of Pediatrics and Adolescent Medicine. 160(3). pp 293-299. doi:10.1001/archpedi.160.3.293.



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