Independent Hospital Pricing Authority
Via email: submissions.ihpa@ihpa.gov.au

CHA response to the Consultation paper on the Pricing Framework for Australian Public Hospital Services 2017-18

Children's Healthcare Australasia (CHA) would like to thank the Independent Hospital Pricing Authority for the opportunity to comment on the Pricing Framework for Australian Public Hospital Services 2017-18. As always; we have distributed the consultation paper widely, and have received numerous comments from our member services across Australia.

Children's Healthcare Australasia (CHA) now represents 91 hospitals and health services across Australia comprising the lion's share of the admissions of neonates, children, adolescents and young people to hospitals and health services across the country. This broad membership and the deep experience of clinicians and hospital administrators from across the country inform our response to this consultation.

Our response in detail

4. CLASSIFICAITONS USED BY IHPA TO DESCRIBE PUBLIC HOSPITAL SERVICES

Consultation question 1: What additional areas should IHPA consider in developing Version 5 of the Australian National Subacute and Non-Acute Patient classification (AN-SNAP)?
CHA members are highly supportive of IHPA's efforts to refine the AN-SNAP classification in recent years through the development and analysis of costing for paediatric palliative care and paediatric rehabilitation and maintenance services. Our members agree that it is appropriate at this point in time to proceed to cost paediatric rehabilitation but that there is as yet insufficient data to accurately cost paediatric palliative care.

CHA members believe that no further areas should be included in this classification at this stage.

Tier 2 Non-Admitted Services Classification

CHA members are in favour of the introduction of additional data items for the counting, costing and classification of **non-admitted multidisciplinary case conferencing where the patient is not present**. Multi-disciplinary case conferences form a vital adjunct to the clinical care of patients with conditions that are long-term and complex. These patients can have a tendency to be otherwise lost to the healthcare system. The complex, on-going nature of their illness means it is better that follow-up care is co-ordinated to ensure that patients are able to access necessary treatment from different specialties, that their condition is relatively stable, and that the healthcare plan is being followed. These patients have the potential to deteriorate quickly, and

subsequent hospital re-admission/s are a potential adverse outcome of loss to follow-up. A number of our members have achieved demonstrable reductions in ED presentations and unplanned admissions by patients with complex care needs following efforts to better coordinate care across specialties through multi-disciplinary case conferencing. The positive health benefits gained from multidisciplinary case conferencing where the patient is not present, far outweighs the cost of funding unplanned admissions that can be required when such conferencing is not undertaken.

Emergency Care Classification

CHA members support IHPA's work towards developing an emergency care classification that is more patient focused. We have appreciated opportunities to provide comment and advice on aspects of this work over the past year and are happy to continue to do so as this work progresses. It is important to ensure that the needs of paediatric patients are considered in the development of a new classification. We have no further comments at this point in time.

Teaching, Training and Research

CHA members note the work IHPA is doing to develop a teaching and training classification, and that the data around research activity does not currently lend itself to classification development. We support the continued block funding of teaching, training and research in NEP17.

Australian Mental Health Care Classification

CHA members have taken an active interest in IHPA's work on developing a new classification to describe and price mental health services. Our members strongly support IHPA's moves to establish a dedicated child & adolescent mental health clinical reference group to inform development of the classification as it relates to mental healthcare of children and young people.

CHA members request that a costing/classification study be undertaken in the Child & Adolescent Mental Health setting. Members note that the original sites selected for the Mental Health Costing Study did not include sizable Child & Adolescent Mental Health services (CAMHS). Members are keen to see a costing/classification study undertaken with a few representative Child & Adolescent Mental Health services and are willing to support IHPA's work to accurately describe and measure the costs of CAMHS.

6. THE NEP FOR ABF FUNDED PUBLIC HOSPITAL SERVICES

Technical Improvements to the Pricing Model to determine the NEP

Consultation question 2 – Should IHPA consider any further technical improvements to the pricing model used to determine the National Efficient Price (NEP) for 2017-18?
CHA members agree that the criteria as outlined for assessing pricing and funding options (preventability, equitable risk adjustment, proportionality, transparency and ease of implementation) is congruent with a patient focused best practice approach.

CHA members propose that a priority be placed on price stability. Particular priority should be placed on leaving the NEP as it is. There is probably an 18 month to 2 year lag in the timeframes in which hospitals and health services can respond to price signals in the market. Some time is required for the effect of changes that have already been made, to be integrated into service thinking and for strategies to enhance efficiency to be implemented. Given this, we believe that the effect of the current NEP should be known before further steps to modify it are undertaken.

Although there are future changes planned with the safety & quality options outlined in this Consultation Paper, CHA members believe that the example as set by the UK in publicly publishing timely safety & quality information (down to clinician level) is one of the most appropriate methods in which to change clinical practice and improve performance in line with safety & quality principles.

Adjustments to the NEP

CHA members support the recommendation that IHPA include all high cost outlier episodes in the calculation of the **Patient Remoteness Area Adjustment** and would also advocate the inclusion of all high cost outlier episodes in the derivation of cost weights.

Stability of the National Pricing Model

Consultation questions 3-5 Should IHPA further restrict year-on-year changes in price weights? What are the priority areas for IHPA to consider when evaluating adjustments to NEP17? What patient-based factors would provide the basis for these other adjustments?
Price instability is a significant concern for CHA member services. The removal of the Psychiatric Age Adjustment had a drastic impact on the funding of some Australian Child & Adolescent Mental Health (C&AMH) Services. The paediatric psychiatric patient adjustment for MDC 19 & 20 in 2014-15 was 30%. This was reduced to 9% in 2015-16. The resultant reduction in funding was not passed on to all C&AMH services as many are currently funded on a per diem basis. We understand that the state based jurisdictions did not contest this change to funding, and believe that given the per diem funding arrangements, the removal of the Psychiatric Age Adjustment did not represent a material change for them. The unfortunate adverse outcome of this was the drastic effect on services who were being funded under Activity Based Funding (ABF) arrangements, including the closure of some much needed child and adolescent mental health beds in the one jurisdiction where the revised price was applied to C&AMH service delivery.

Given the above example CHA members believe that future changes to price weights need to be considerably restricted in magnitude to reduce the potential for unintended adverse impacts on health service delivery.

7. SETTING THE NATIONAL EFFICIENT PRICE FOR PRIVATE PATIENTS IN PUBLIC HOSPITALS

Costing Private Patients in Public Hospitals

Consultation question 6 - Should IHPA phase out the private patient correction factor in 2018-19 if feasible to do so?
CHA members agree with the phasing out of the private patient correction factor in 2018-19 as suggested in the consultation paper.

11. PRICING AND FUNDING FOR SAFETY & QUALITY

Scope and Approaches to Pricing and Funding for Safety & Quality

Consultation questions 11 - Is there support for pricing and funding models for safety and quality to be applied broadly across all types of public hospitals, all services, all patients and all care settings?
CHA supports IHPA's general direction to consider safety and quality factors in pricing and funding of hospital care.

CHA members are not in favour of the early introduction of a pricing system for safety and quality. Members believe that significantly more work is required to identify the right datasets and information to capture these patients and that considerable focus is required to make sure that the right behaviours are being incentivised through this approach. Rather than moving forward quickly, a measured and staged approach needs to be taken. It would be preferable that the expected outcomes of reporting were identified and qualified so that when a system of reporting is introduced known outcomes will be achieved.

CHA members were united in the opinion that, in the first instance, effort should be directed towards incentivising good quality health care rather than penalising poor outcomes.

Consultation questions 12 - What factors should be considered in risk adjustment for safety and quality in pricing and funding models for hospital care?
Factors that should be considered in the calculation of risk adjustment include co-morbidities, chronic health conditions, age, gender, & socioeconomic status. It will also be important to consider how cases are handled where more than one hospital has been involved in contributing to the care of a patient deemed to have a preventably poor outcome.

Consultation questions 13 - Do you agree with the use of these assessment criteria to evaluate the relative merit of different approaches to pricing for safety and quality? Are there other criteria that should be considered?
CHA supports the 5 criteria identified in the Consultation Paper.

Sentinel Events

Consultation questions 14 – 16 Do you support the proposal to not fund episodes that include a sentinel event? If not, what are the alternatives and how could they be applied consistently?

CHA members agree in principle with the concept of not funding episodes that include a sentinel event. Our members noted that sentinel events in children not uncommonly result in litigation with significant financial penalties imposed by courts, that already serve as a deterrent from errors causing harm to children, if any such additional deterrent is needed given no clinical teams ever wish avoidable harm on a child.

Implementation of such a policy will, however, require careful consideration & development of data and reporting systems, as IHPA has already identified. All children's services have systems in place to report and investigate sentinel events and such events are thankfully rare. However discussions with members have identified that these systems vary between and even within jurisdictions, in terms of the events that are reported and the process used to investigate them. In some coroner's cases, services have been praised for their prompt review and timely implementation of changes to reduce the risk of a future event. In other cases, identification of the causes for a child's death and the extent to which it could have been prevented take many years. These differences make the prospect of adjustments to funding for such episodes more complex. A methodical and staged approach needs to be taken to its adoption and implementation.

Consultation questions 15 - Do you support the proposal to include a sentinel events flag to improve the timeliness and consistency of data that is used for funding purposes?
CHA is aware of the work of the ACSQHC to develop a national reporting system for sentinel events. Completion of this work would seem to be a necessary precursor to implementation of a funding policy for sentinel events. CHA supports the proposal that a flag be developed to identify sentinel events to improve the timeliness and consistency of the data. There is also a need for greater ease of sharing learnings from sentinel events across services.

Hospital Acquired Conditions (HAC):

CHA members agree that it is important to take account of Hospital Acquired Conditions, including nosocomial infections. Some members felt that many of the conditions in IHPA's list would be more likely to start before, rather than during admission, and that this would be the case in particular in the paediatric setting. Members indicated that they would like to see clear definitions applied to each of the elements that are included in the final HAC listing.

CHA members warn that there are significant risks to basing hospital funding on a variance in HAC rates that may be influenced by poor coding practices as opposed to true performance around hospital-acquired complications.

CHA members suggest that there is a need to reconsider, and preferably remove Neonatal Birth Trauma from the HAC listing. Neonatal Birth Trauma has not been clearly defined in the consultation paper, and this term alone is not sufficiently specific to be able to identify a critical incident type event. There are instances when neonatal birth trauma may be induced because a clinician intends to avoid the more serious consequences. Good examples of this include shoulder dystocia where the clinician will manoeuvre the baby to effect delivery which may result in a break to the clavicle of the baby but can be necessary to prevent Hypoxic Ischemic Encephalopathy (HIE). Experts also note that a neonate may sustain spontaneous bruising during birth as an entirely normal birth outcome. They also note that Australian rates for spina bifida

have not changed in 30 years. If pricing for safety & quality is to be applied it should be applied in areas that are amenable to improvement. Given this, we suggest that neonatal birth trauma should either be carefully re-defined (with a linked expected outcome) or removed from the list of HACs. Our preference is that Neonatal Birth Trauma be removed from the listing until such time as evidence based criteria and a direct link to expected quality & safety outcomes are established.

Lastly, CHA notes that many countries now have a separately constituted national level body that has been established to decide if adverse outcomes are clinically induced or the result of other adverse factors that are outside of the clinician's control. It may be that if Australia were to implement penalties for HACs that we would need such a body as well.

Members indicated that the HAC listing should include:

- Pressure injuries occurring after admission
- Falls occurring in the healthcare setting resulting in fracture or intracranial injury
- Surgical site infection
- Central Line Associated Blood Stream Infection (CLABSI)
- Infection associated with prosthetics or implantable devices
- Surgical complications of Pulmonary Embolism and Deep Vein Thrombosis, and
- Adverse outcomes as a result of medication administration in the healthcare setting.

Our members also feel that each of the 3 options for HACs has a downside that needs to be considered before progressing the pricing of HACs. They are outlined below:

Consultation questions 17-18 What are the advantages and disadvantages of Option 1 which reduces funding for some acute admitted episodes with a HAC? Do you agree with IHPA's assessment of this option [1]?

If HACs are removed from the DRG assignment this would lead to a lower DRG weight, but it does not allow for detailed analysis of the conditions at the hospital site/local level, if these codes are removed. Best practice care should allow for review of data/cases and rectification of practice at the local level in the first instance.

Consultation questions 19-21 What are the advantages and disadvantages of Option 2 that adjusts funding to hospitals on the basis of differences in their HAC rates? Do you agree with IHPA's assessment of this option [2]? What are the advantages and disadvantages of the approaches to risk adjustment?

This option adjusts funding made on the basis of differences in HAC rates across hospitals, it is a more preferable option, but our members have concerns as to the transparency of the application of the funding reduction, and believe that detailed reporting and education from IHPA would need to accompany this.

Consultation questions 22-23 What are the advantages and disadvantages of Option 3 that combines funding incentives and penalties? Do you agree with IHPA's assessment of this option [3]?

Option 3 that combines funding incentives as well as penalties, is probably best implemented further down this journey.

Consultation question 24 - 25 Are there any other pricing or funding options that IHPA should consider in relation to HACs? How should IHPA treat hospitals with poor quality Condition Onset Flag (COF) reporting?

Avoidable Hospital Readmissions

Our members worry about the consequences of penalising re-admission. There are psychological risks to being in hospital and the ever prevalent risk of nosocomial infection. Attempts to reduce length of stay will inevitably result in some increase of re-admission of patients found in retrospect to have been not quite ready for discharge. A short re-admission for one patient may be an acceptable risk for another 19 who are successfully discharged a little earlier. The current enthusiasm for Hospital in the Home is another manifestation of this approach.

Identifying avoidable readmission to hospitals is a complex issue and this is particularly the case for specialist services. We would suggest that monitoring the inter-LHD/network readmissions be undertaken to ensure that there is equity in the system for this adjustor by identifying the extent to which this may occur.

Our members suggest that a variety of models of care need to be considered in the determination of which conditions would be tagged as preventable. Regular re-admissions are planned in a number of best practice models of care, such as for example in caring for children with eating disorders.

Member hospitals also comment that in many circumstances re-admission to services is routine. Instances in which this might occur include where a neonate is delivered at one hospital, transferred to another hospital for surgical procedures/care, and then readmitted back to the original or another hospital for post op/ongoing care. This is routine in many services. Examples might include the relationships set up between Mater Mothers Hospital in Brisbane and Lady Cilento Children's Hospital, those between King Edward Memorial Hospital in Perth and the Princess Margaret Hospital, and those between Westmead Hospital and the Children's Hospital at Westmead. We would like to point out that this is also the case between tertiary centres and regional centres and step-down services in metropolitan areas as well.

Consultation questions 26-29 What approach is supported for setting timeframes within which avoidable hospital readmissions are measured? Is there Australian evidence (including guidelines or recommendations) that could be used to implement condition specific readmission timeframes? Is there support for pricing and funding models to be based on avoidable hospital readmissions within the same LHN? When should a pricing and funding approach for avoidable readmissions be implemented?

Our members believe that because these types of practices are new that the reliability of the data needs to be determined in the first instance. This form of pricing should not proceed until it is known that the data truly reflects local rates.

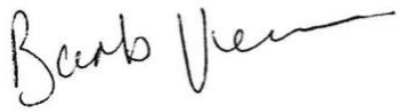
Our members believe that until a unique identifier exists across all hospitals, a pricing penalty for avoidable readmissions need to be limited to the same hospital.

If a timespan was implemented, we would suggest a 28 day readmission rate as per many other current reporting mechanisms.

Our members suggested that re-presentations to the Emergency Department post admitted episode should be excluded from the definition of re-admission unless this results in a further admission.

We thank you for the opportunity to provide comment in response to the Consultation paper on the Pricing Framework for Australian Public Hospital Services 2017-18. We would be happy to provide an opportunity for IHPA to discuss any elements of this submission in further detail with our members if required.

Yours sincerely,



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Chief Executive Officer

28 October 2016