Children's Health Queensland Response

IHPA Consultation paper

Pricing Framework for Australian Public Hospital Services 2020–21

Dated: 11 July 2019

Consultation question	Feedback
1. Are the Pricing Guidelines still relevant in providing guidance on IHPA's role in pricing Australian public hospital services?	Yes, the guidelines provide a consistent reference point.
2. Does the proposed addition to the Pricing Guidelines appropriately capture the need for pricing models to support 'value' in hospital and health services?	Yes, a flexible funding model to support 'value' is key to driving innovation. A rigid Activity Based Funding model can act as a disincentive for Hospitals and Health Services implementing model of care changes.
3. What should IHPA prioritise when developing AR-DRG Version 11.0 and ICD-10-AM/ACHI/ACS Twelfth Edition?	A review of the Major Diagnostic Category 'Newborns & Other Neonates' is recommended to better identify the underlying casemix/ reason for hospital admission. Revision of Epilepsy in line with International League Against Epilepsy (ILAE) classification. ACHI to be considered in paediatric procedure classification eg. PEARS procedure for paediatric cardiac patients.
4. Are there other priorities that should be included as part of the comprehensive review of the admitted acute care classification development process?	None identified by Children's Health Queensland (CHQ).
5. Are there any impediments to implementing pricing using the AECC Version 1.0 for emergency departments from 1 July 2020?	None identified by CHQ.
6. Are there any impediments to implementing pricing for mental health services using AMHCC Version 1.0 from 1 July 2020?	None currently identified by CHQ, interested to see outcomes of shadow pricing.

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7. Are there adjustments for legitimate and unavoidable cost variations that IHPA should consider for NEP20?	(i). As presented at the ABF 2019 Conference, the high cost of treating patients in Intensive Care Units (ICU) is recognised in the 2018-19 National Efficient Price Determination through the provision of a price adjustment based on the time a patient spends in ICU. This adjustment is applied to all patients utilising ICU except those assigned a Major Diagnostic Category (MDC) of 'Newborns and Other Neonates' (Neonates), where the AR-DRG price is inclusive of a 'Bundled ICU' component. This differential model for patients requiring treatment in Intensive Care Unit (ICU) with neonates funded on a bundled, semi-fixed price and non-neonates funded on a variable rate determined by the length of stay in ICU combined with the high variability in length of stay in ICU for neonatal patients (including patients who do not require ICU) compromises the veracity of the 'bundled ICU' component of the DRG price. Complex, long stay patients that require significant time in ICU and are typically transferred from other hospitals to specialist paediatric, quaternary facilities are significantly underfunded while less complex patients that do not require treatment in ICU are overfunded. It is recommended IHPA consider unbundling the ICU component of the DRG price for Newborns and Other Neonates to provide consistency for all patients treated in an ICU and create a more transparent and equitable model. (ii). The current ICU-adjusted LOS funding methodology can result in a differential level of patient funding for those patients who spend their entire episode in PICU/ICU and are determined as 'Short Stay Outliers'. The resulting lower level of funding compared to patients who receive combined PICU/ general ward care is inconsistent with the Pricing Guidelines and does not reflect the cost profile of this patient cohort. Example: AR-DRG A40Z ECMO –There is a wide underlying casemix for paediatric patients receiving ECMO/ECLS and length of stay and models of care for this patient cohort are variable. In 2018/19 QCH treated 21 ECMO patients with a total length of stay (LOS) range of 2 days to 329 days with a PICU LOS range of 2 to 297 days (5 patients spent their entire episode in PICU). The example below shows the impact of the Short Stay Outlier adjustment on the funding of one patient who had a 51 day Length of Stay (entirely in PICU), which is $104,640 less than if the patient had stayed 47 days PICU and 4 days general ward.

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	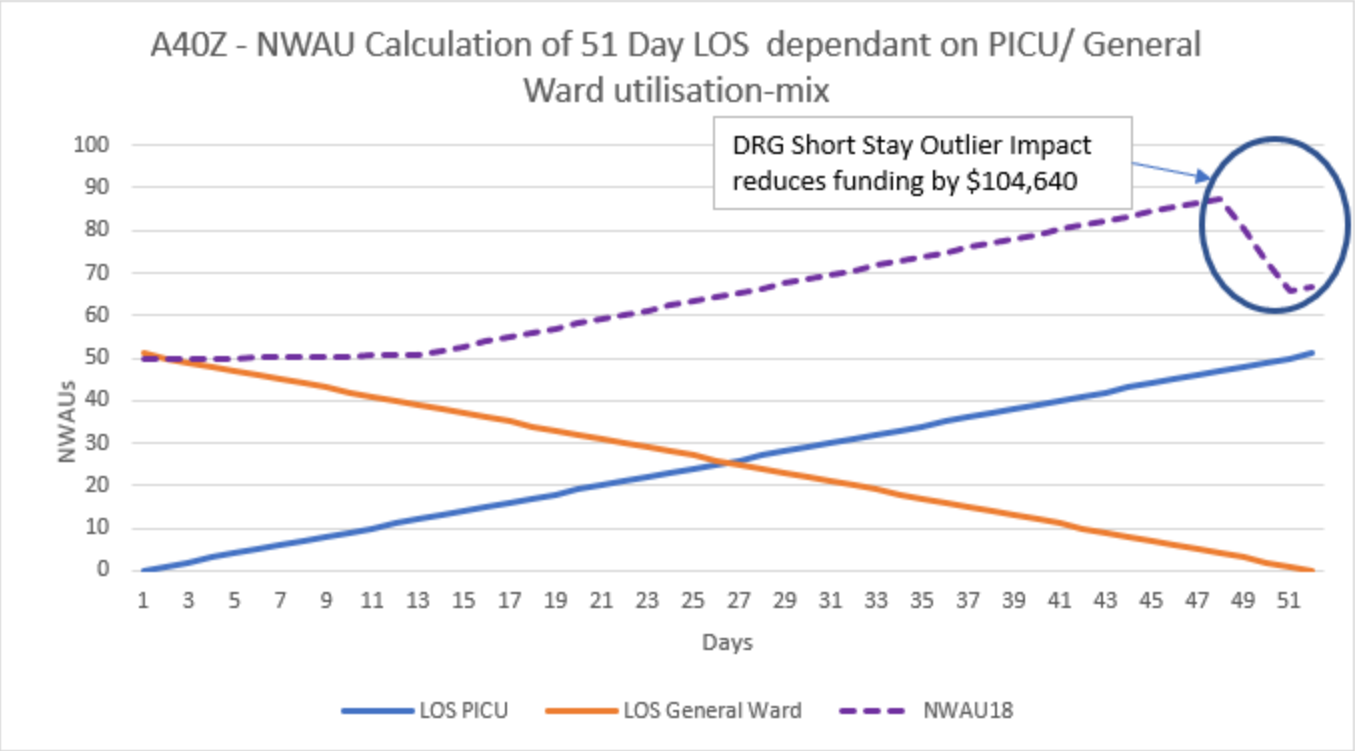
8. Is there any objection to IHPA phasing out the private patient correction factor for NEP20?	None in principal, subject to outcomes of Round 22 NHCDC Cost Report assessment.
9. Do you support IHPA making the NBP publicly available, with appropriate safeguards in place to protect patient privacy?	CHQ make regular use of the National Benchmarking Portal and support the proposal to make the NBP publicly available, with appropriate user guidelines and safeguards to protect patient privacy.

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10. What are the estimated costs of collecting the IHI in your state or territory?	Nil response
11. Would you support the introduction of an incentive payment or other mechanism to assist in covering these costs for a limited time period?	Nil response
12. What initiatives are currently underway to collect PROMs and how are they being collated?	A PROM Research Advisory Group has been established which will oversee and coordinate all PROM research currently underway at CHQ. In time this group will assist and inform on the clinical integration of specific PROM's into routine clinical practice. The main themes of current PROM research is around developing new, validating current, and evaluating effectiveness of paediatric PROMs. The Child and Youth Mental Health Service use a national suite of outcome measures, one being the Strengths and Difficulties Questionnaire, which is completed by parents, young people over 10 years and teachers. The other measures are clinician rated. These are administered at the beginning of a service episode, at three monthly intervals and at the end of a service episode. CHQ have an annual 'Your Experience of Service' questionnaire which is statewide administered and compiled by the Mental Health Alcohol and Other Drug Branch (MHAODB). This also reflects client feedback about treatment outcomes, there is a young person's report and a carers report. For mental health, CHQ believe further PROM's would be burdensome as many specialist programs have additional evaluation measures they use, so families and young people are already engaging in regular feedback mechanisms.
13. Should a national PROMs collection be considered as part of a national dataset?	No, CHQ does not support the development of a national dataset, the focus of PROMs is mostly to assist support of patients to make informed, shared decision about their own care needs. They are not a tool for statistical comparisons.
14. Are there any impediments to shadow pricing the 'fixed plus variable' model for NEC20?	None identified by CHQ.
15. Are there any additional alternative funding models IHPA should explore in the context of Australia's existing NHRA and ABF Framework?	CHQ support the exploration of alternative funding models including Capitation and bundled payments.
16. IHPA proposes investigating bundled payments for stroke and joint pain, in particular knee and hip replacements. Should any other conditions be considered?	CHQ support the investigation of potential Chronic and Acute Paediatric conditions that may be suitable for bundled payments, in particular, bundled payments for paediatric cardiac surgeries.
17. Is IHPA's funding approach to HACs improving safety and quality, for example changing clinician	CHQ believe it is too early to assess the impact of IHPA's funding approach to HACs on improving Safety and Quality due to a number of issues:

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behaviour and providing opportunities for effective benchmarking?	(i). HAC data reliability – HAC identification is dependant on clinically coded information informed by varying levels of completeness and accuracy documented by clinicians. (ii). Identification of genuine improvements in Safety and Quality (reduction in HACs) compared to improvements resulting from improved administrative/ documentation processes. It is also recommended that IHPA undertake further evaluation regarding the preventability of HACs. CHQ do not support the following as HACs for paediatrics: - HAC 6 Aspiration Pneumonia and Vent Associated Pneumonia – some paediatric patients are extremely complex, with Cerebral Palsy, Dysphagia etc and on extubation these conditions will often develop and is an expected outcome for these children. - HAC 8 Renal failure procedure – (including intermittent haemofiltration, intermittent haemodialfiltration) should not be included in HAC's as it is not always performed for renal failure especially for congenital heart surgeries and ECMO cases.
18. What should IHPA consider to configure software for the Australian context that can identify potentially avoidable hospital readmissions?	The definition of potentially avoidable readmissions should be developed in consultation with clinicians. If commercial software is to be considered it is recommended that the ACSQHC lead a thorough audit of the proposed software to determine the true preventability of the readmissions to determine how effective these measures can be in driving safety and quality improvement. This would also assist in determining the funding approach… i.e. if it can be determined that x% are preventable, then the funding approach can be more targeted on penalising the x%.